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WHAT ARE THE COMPONENTS OF HUMANIZED CHILDBIRTH IN A HIGHLY SPECIALIZED HOSPITAL? AN ORGANIZATIONAL CASE STUDY

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Résumé

De nombreuses études ont mis l'accent sur le concept de l'humanisation des soins de naissance d'une grossesse normale ou à faible risque obstétrical. Mais, à notre connaissance, aucune étude à ce jour n'a spécifiquement porté sur l'humanisation des soins de la naissance dans les grossesses à haut et à faible risque dans un hôpital hautement spécialisé. La présente étude vise à: 1) définir les composantes spécifiques de l'humanisation des soins qui apportent satisfaction aux femmes qui cherchent des soins obstétricaux dans un hôpital hautement spécialisé; 2) explorer les dimensions organisationnelles et culturelles qui constituent des obstacles ou des facilitateurs pour les pratiques périnatales favorisant l'humanisation des soins dans un centre hospitalier universitaire très spécialisé, au Québec.

Une étude de cas unique a été choisie pour notre thèse. Les données ont été recueillies au moyen d'entrevues semi-structurées, de notes de terrain, d'observation des participants, d'un questionnaire auto-administré, et de documents et d'archives pertinents. L'échantillon est composé de : 11 professionnels de différentes disciplines, six administrateurs de différents niveaux hiérarchiques de l'hôpital et 157 femmes qui ont accouché à l'hôpital durant la période de l'étude. Une analyse à la fois descriptive quantitative et qualitative déductive et inductive a été réalisée.

La thèse comprend trois articles. Dans le premier article, nous proposons un cadre conceptuel fondé sur la théorie de la culture organisationnelle développée par Allaire et Firsirotu (1984). Le but de cet article est d'examiner les tendances d'accouchement en tant que phénomène de culture organisationnelle. Le second article, répond à une question spécifique : quelle est la définition des soins humanisés selon les administrateurs et des professionnels multidisciplinaires œuvrant dans un hôpital hautement spécialisé, ainsi que celle des femmes soignées dans cet hôpital ? L'analyse des données permet de ressortir les thèmes suivants sur la perception de l'humanisation de la naissance : les soins personnalisés, la reconnaissance du droit des

femmes, des soins humains, des soins centrés sur la famille, la défense des femmes et de leur compagnon, le compromis de sécurité, le confort et l'humanité, et les grossesses non stéréotypées. Les femmes à risque élevé et à faible risque semblent plus satisfaites des soins s'ils sont fournis selon un choix éclairé et qu'elles ont participé au processus décisionnel, tout en étant entourées par des fournisseurs de soins compétents, qui soignent de façon humaine et font des interventions médicales lorsque requises. Les perceptions des professionnels et des administrateurs à propos de la naissance humanisée mettent principalement l'accent sur des soins personnalisés et centrés sur la famille.

Dans notre troisième article, nous traitons les composantes internes et externes d'une institution, qui prédisposent ou qui empêchent un hôpital spécialisé et universitaire affilié au Québec d'adopter des soins humanisés de naissance. Les résultats révèlent qu'à la fois des dimensions externes d'un hôpital hautement spécialisé, -son histoire, son affiliation, et ses contingences - ainsi que des dimensions internes- sa culture, sa structure et ses individus - peuvent tous influer sur l'humanisation de la pratique des soins de naissance dans un tel établissement, que ce soit séparément, simultanément ou en interaction.

Nous avons donc conclu que l'humanisation des soins de naissance dans un l'hôpital hautement spécialisé doit répondre à tous les aspects physiologiques et psychologiques des soins périnatals dont le respect des craintes, des croyances et des valeurs et besoins des femmes et de leur famille. L'intégration de professionnels compétents et attentionnés utilisant la technologie obstétrique améliore le niveau de certitude et d'assurance dans les grossesses à haut et à faible risque dans un hôpital hautement spécialisé. Enfin, l'humanisation de l'approche de la naissance dans un centre hospitalier très spécialisé et universitaire affilié requiert des nouvelles politiques de système de santé. Une telle politique garantit, pour une femme enceinte dès le début de sa grossesse, une place dans une institution, un professionnel de la santé de son choix et la possibilité de faire des choix éclairés tout au long du processus de la naissance.

Mots-clés : humanisation des soins de naissance, culture organisationnelle, satisfaction dans la naissance de l'enfant, centre de soins périnatals spécialisé, grossesse à faible et à haut risque.

ABSTRACT

Many studies have focused on the concept of humanization of birth in normal pregnancy cases or at low obstetric risk, but no studies, at our knowledge, have so far specifically focused on the humanization of birth in both high-risk, and low risk pregnancies, in a highly specialized hospital setting. The present study thus aims to: 1) define the specific components of the humanized birth care model which bring satisfaction to women who seek obstetrical care in highly specialized hospitals; and 2) explore the organizational and cultural dimensions which act as barriers or facilitators for the implementation of humanized birth care practices in a highly specialized, university affiliated hospital in Quebec.

A single case study design was chosen for this thesis. The data were collected through semi-structured interviews, field notes, participant observations, self-administered questionnaire, relevant documents, and archives. The samples comprised: 11 professionals from different disciplines, 6 administrators from different hierarchical levels within the hospital, and 157 women who had given birth at the hospital during the study. The performed analysis covered both quantitative descriptive and qualitative deductive and inductive content analyses.

The thesis comprises three articles. In the first article, we proposed a conceptual framework, based on Allaire and Firsirotu's (1984) organizational culture theory. It attempts to examine childbirth patterns as an organizational cultural phenomenon. In our second article, we answered the following specific question: according to the managers and multidisciplinary professionals practicing in a highly specialized hospital as well as the women seeking perinatal care in this hospital setting, what is the definition of humanized care?

Analysis of the data collected uncovered the following themes which explained the perceptions of what humanized birth was: personalized care, recognition of women's rights, humanly care for women, family-centered care, women's advocacy and companionship, compromise of security, comfort and humanity, and non-stereotyped pregnancies. Both high and low risk women felt more satisfied with the care they received if they were provided with informed choices, were given the right to participate in the decision-making process and were surrounded by competent care providers. These care providers who humanly cared for them were also able to provide relevant medical intervention. The professionals and administrators' perceptions of humanized birth, on the other hand, mostly focused on personalized and family-centered care.

In the third article of the thesis, we covered the dimensions of the internal and external components of an institution which can act as factors that facilitate or barriers that prevent, a specialized and university affiliated hospital in Quebec from adopting a humanized child birthing care. The findings revealed that both the external dimensions of a highly specialized hospital -including its history, society, and contingency-; and its internal dimensions -including culture, structure, and the individuals present in the hospital-, can all affect the humanization of birth care in such an institution, whether separately, simultaneously or in interaction.

We thus hereby conclude that the humanization of birth care in a highly specialized hospital setting, should aim to meet all the physiological, as well as psychological aspects of birth care, including respect of the fears, beliefs, values, and needs of women and their families. Integration of competent and caring professionals and the use of obstetric technology to enhance the level of certainty and assurance in both high-risk and low risk women are both positive factors for the implementation of humanized care in a highly specialized hospital. Finally, the humanization of birth care approach in a highly specialized and university affiliated hospital setting demands a new healthcare policy. Such policy must offer a guarantee for women to have the place of birth, and the health care professional of their choice as well as

those, which will enable women to make informed choices from the beginning of their pregnancy.

Keywords: Humanization of birth, organizational culture, childbirth satisfaction, specialized perinatal health care institution, low and high-risk pregnancies

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Dedicated to my parents
and Zia, Kiamehr, Kamyar

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CHAPTER I: GENERAL INTRODUCTION

Childbirth is considered as one of the most important events in a women's life, as it can affect women both physically and emotionally. (Jordan & Davis-Floyd, 1993) During the past decades, giving birth has been an increasingly medicalized procedure in most of countries and humans have basically been replaced by machines in order to bring more security to procedures to reduce the associated risks. (Hausman, 2005). Medical interventions in childbirth, such as use of electronic fetal monitoring (EFM), epidural analgesia, amniotomy, induced labour, episiotomy, and elective caesarean section deliveries increased around the world, especially in North America. (Chalmers, Dzakpasu, Heaman, & Kaczorowski, 2008; Dzakpasu, et al., 2008)

In Canada, the preterm birth rate has increased over the last few decades and reached 8.3 % in 2006-2007 (CIHI, 2010). The preterm birth rate was seen to be markedly higher among babies delivered by cesarean section (13.3%), compared to non-induced (6.5%) or induced (6.9%) vaginal deliveries, and electronic fetal monitoring (EFM) rates are also on the rise in Canada. The American Centre for Disease Control and Prevention (CDC) has shown that the use of EFM in the USA has increased from a rate of 68.4% in 1989 to 85.2% in 2002 (Martin, Hamilton, & Sutton, 2003). Davies' study (2002) also showed that the use of electronic fetal monitoring (EFM) varied between 84.4% and 99.3% in the studied hospitals in Canada (CPSS, 2008). This was even before investigators applied their interventional study (Levitt, Hanvey, Avard, Chance, & Kaczorowski, 1995). The inductions accounted for 20% of all in-hospital births in Canada in 2006 and 2007(Kirkey, 2009), and an even higher induction rate (25%) was reported by the Society of Obstetricians and Gynecologists of Canada (Canada, 2003) and Canadian Perinatal Survey (44%) (CPSS, 2008).

The obstetric interventions have provided women with a sense of security for their child and themselves, as well as options to reduce or avoid

labour pain (Roland-Schwartz, 2007). For example, a caesarean section can save the life of both mother and her baby(Wagner, 2001) .However, the increased medicalization of birth, and the routine obstetrical interventions have been shown to be harmful to women in labour, and to their babies (Zeldes & Norsigian, 2008). The findings of a study (Donna, 2002) have shown that American women who undergo caesarean sections, are four times more likely to die compared to women who opt for vaginal births. This fact still held for elective caesarean sections, where the maternal mortality rate was 2.84 times higher than that of vaginal births (Hall & Bewley, 1999). Babies who were born by elective caesarean, were also found to be five times more likely to require breathing assistance, and five times more likely to be admitted to intermediate or intensive care (Annibale, 1995). A recent research has shown that opting for a caesarean section can prevent the phenomenon of the colonization of the neonate's intestinal microbiota, which plays an important role in the development of the postnatal immune system (Biasucci, Benenati, Morelli, Bessi, & Boehm, 2008).

The literature shows that epidural analgesia is associated with prolonged labour, an increased incidence of maternal fevers, increased rates of operative vaginal deliveries, and third, as well as fourth degree perineal tears (Anim-Somuah, Smyth, & Howell, 2005; Howell, 2004; Leeman, Fontaine, King, Klein, & Ratcliffe, 2003). However, the association between epidural analgesia and increased caesarean delivery rates is controversial. A study by Klein (2006) did not support this association in cases where the epidural was given during the active phase of labour (Michael Klein, 2006).

Long-term effects have been related to instrumental deliveries. These include: dyspareunia, and incontinence (Clakson & Newton, 2001; Thorpe, Daniel, & Rene, 1993). With continuous EFM, women have to remain in bed; which essentially eliminates the support of walking during early stages of labour, or the choice of changing postures (Hausman, 2005). Moreover, use of

EFM leads to quicker detections of fetal distress, which are frequently managed by caesarean section. The use of EFM has been shown to increase the caesarean section rates by 10 % (ACOG, 2003).

The increasing use of medical intervention during childbirth is a phenomenon that adds to the public health care costs. Many caesareans can, in fact, be viewed as unnecessary surgeries that result in more medical complications, and which can cost up to three times more than vaginal births (Tew, 1998; Walker, Turnbull, & Wilkinson, 2002).

Likewise, another important consequence of the medicalization of childbirth, is that it changes the natural views of the childbirth process in women's minds, and of their lives (Rothman, 1982). As control is limited to the medical providers, the women-providers relationship is asymmetrical, and the health provider will always be more autonomous, while the women are more dependent (Enkin, 2000). Health providers accomplish their tasks and standard procedures in accordance with hospital policy, while it does not necessarily intend to meet the needs of mothers, such as being listened to, being able to be involved in decision-making, and being offered choices (Holroyd & James, 2002). In the medical model of childbirth, women have very little, or no voice in the childbirth, or the decision making process. If a woman does not follow the health provider's explanations, she can be held accountable for a poor pregnancy outcome, implying that in these cases, these processes suddenly become the woman's responsibility (Jordan & Davis-Floyd, 1993; Lazarus, 1994).

The humanization of birth is an alternative model to the medical and technological childbirth models. This model puts the woman in control of her own childbirth, in order to allow her to contribute to making all the decisions about what will happen to her, as well as to her baby (Page, 2000; Umenai & Wagner, 2001). Following this, women would be able to maintain control over

the outcome of their birth, as well as being responsible for the management of their childbirth pain. This way, they can also be in control of their fears of a normal childbirth (Armstrong, 2000; Enkin, 2000). The humanization of birth is supposed to enhance women's self-confidence, whilst aiding them to form a bond with their babies, and to be more competent in their roles as parents (Page, 2000). The key principles for this are: choice, continuity, and control (Pope & Graham, 2001).

In Quebec, the first critics of medicalized birth appeared by a women's group aiming to change childbirth practices towards a more humanized approach (ASPQ, 1980). These critics followed the recommendations for the changing of birth practices by the Committee of Midwifery Practice in Quebec, and the Medical Subcommittee of Humanizing the Obstetric care (M Klein, 1985). Nearly three decades later, the concept of humanized birth is still a topic under debate (Vadeboncoeur, 2004).

The findings of a study by Vadeboncoeur (2004) in Quebec hospitals showed that although there have been some positive changes compared to twenty-five years ago, it demonstrates that childbirth was not really de-medicalized at the time of her study (Vadeboncoeur, 2004). Apparently, the informed choice was not being carried out, and health provider's views on the management of labour seem to dominate over any of the decision-making processes. The Vadeboncoeur (2004) study was carried out in a second-level hospital where births were mostly associated with low obstetrical risk. Nevertheless, she does not propose a conceptual framework, nor does she consider the influences of organizational components on the humanized birth practice (Vadeboncoeur, 2004).

As a matter of fact, institutions providing care are divided into different levels of specialty concerning patients' needs; therefore, their services are expected to be different. Level 1 hospitals are only equipped to handle normal,

uncomplicated pregnancies and deliveries. Level 2 hospitals have supplementary equipment and professionals who are trained to provide care for patients with a minimum pregnancy risk-potential. Level 3 hospitals, on the other hand, have the necessary equipment and staff required to manage very complicated births, including those with a risk of serious illness or abnormality requiring intensive care for the mothers, or the newborns, before, during, and/or after delivery. Level 4 hospitals provide a wide-ranging array of critical care practices for the newborn, and offer a full range of specialty services. Levels 2, 3, and 4 hospitals also provide care for uncomplicated births. What is different about the present thesis, is that it looks at the humanization of birth in a highly specialized hospital setting (levels 3 and 4), and thus brings insights and thereby a new perspective on the technological model of care which is provided for women in such a setting.

In the context of a highly specialized hospital, most pregnancies are at high-risk and thus have special needs which require immediate attention and care that surpass the needs of women undergoing normal pregnancies and labour. One may therefore expect that care in this setting might be different, and could be considered as less humanized. The concept of 'risk' is used in these situations for the negative connotations that women have to face regarding their pregnancy (Lindsay, 2006). Apart from the source of risk itself, this label produces stress and anxiety which can influence the outcome of a pregnancy. Therefore, the most important role of health providers is in fact to focus on normality in the midst of an abnormal situation (Lindsay, 2006). Thus, any attempt to provide humanized birth care in such a setting depends on women's perceptions, and on the definition of normality. This definition is regarded as the basis of women's perceptions of the care-giving organization, and of the severity of risk they possess (Lindsay, 2006). Women's assessment of risk, as well as their hopes, and their desires, are socially-shaped phenomena, and may play an important role on their decision making during the childbirth process (Hirschmann, 2003, p 80).

One can question the nature of the care that is generally sought by women confronted with a high-risk pregnancy or labour. Can the humanized birth care approach, as defined in the literature, apply to their case? What kind of care would women with complicated pregnancies or deliveries expect? Knowing this, these complicated conditions will undoubtedly require obstetrical care in a highly specialized hospital. What are the expectations of the pregnant and child-birthing women without such complications who still seek obstetrical care in this kind of health institution? The present study attempted to answer all these questions, whilst also contributing to the development of previous knowledge regarding the characteristics of humanizing childbirth on both normal and high-risk pregnancy cases. This was applied to the context of highly specialized hospitals, and it was carried out using an organizational culture model theory. The highly specialized environment of a hospital has its own rules, regulations, standards, and technology with which women and their families must comply. The organizational culture study carried out here allows us to study the complex structural, cultural, social, historical, and political context of a highly specialized hospital in which both the women and the professionals make their choices.

Considering the importance of childbirth , there is still a clear necessity for conducting more research in this field. Moreover, understanding the evolution of a health care institution, which deals with such an important concept every day, may lead to re-organizing some of the birth practices.

This study aims: 1) to define the specific components of the humanized care that brings satisfaction to the women who seek obstetrical care at a highly specialized hospital; 2) to explore the organizational and cultural dimensions which would act as barriers or facilitators for birth practices ensuring

humanizing care in a highly specialized, and university affiliated hospital in the province of Quebec**.**

The findings of the present study have been used in developing a conceptual framework in order to promote humanization of childbirth in the highly specialized hospital under this study

Outline of the thesis

We present this thesis in three separate research articles. Each article addresses a separate question that is coherently linked to support the argument that childbirth is a cultural and social practice. The literature review following the introduction serves to present the progress and the limits in current public health research with regards to the humanization of birth care practice. It also identifies the need for innovative perspectives and theory aiming to understand childbirth as a cultural and social phenomenon

The first article outlines the theoretical framework of Allaire and Firsirotu (1984) that is the foundation of this thesis. We borrowed the concepts of *history, ambient society, contingency, culture, socio-structures, and individuals* from Allaire and Firsirotu's organizational culture theory to examine childbirth care as a cultural and social practice. We thus propose our research questions that have been raised from the literature review of the present study.

The study methodology provides a detailed description of the study design and context. The study population and recruitment procedures are presented. Data collection and analysis methods are briefly discussed while more details are found in the second and third articles. Finally, the trustworthiness of the findings is described in detail.

The purpose of the second article was to identify the perceptions of professionals, administrators, and women on the humanization of childbirth care in a highly specialized hospital. The third article of the study pursues the main objective of research aiming to explore the organizational and cultural dimensions, which act as barriers or facilitators in assuring humanized care in the birth practices of a highly specialized, university-affiliated hospital in Quebec. Through the articles, we also describe the specific components of the

humanized care that brings satisfaction to the women who seek obstetrical care at a highly specialized hospital.

In the discussion section, we synthesize the findings of our study. The clinical relevance of the present study and implications for future studies are discussed and the strengths and limitations are outlined. Finally, we present the conclusion of the dissertation.

CHAPTER II: LITERATURE REVIEW

1. BACKGROUND

1.1. A Brief History of Birth in North America

In America, as in most parts of the world, giving birth in a hospital was highly uncommon before the 20th century, where births were attended by women (Jordan & Davis-Floyd, 1993). Near the end of the 19th century, male-dominated obstetric professions began to replace the female midwives in attending births. By the 1920s, the rate of hospital births seemed to have accelerated in most countries, and about half of all births began taking place in hospitals (Wertz & Wertz, 1989). The majority (97.9%) of births occurred in hospitals, only 1.2% of births took place in a private home and (0.8%) took place in a birthing centre (CPSS, 2008). At the same time, not only childbirth practice changed and interventions were introduced, but the women's views about childbirth and ultimately their experiences also changed. Women's acceptance of medical technology led to set the more technological birth in order to provide the perfect birth. The criteria for childbirth in the 20th century were: the growth of the authority of obstetricians over birth; the training of obstetric surgeons; and the dependence on medical technology to differentiate normal pregnancy, labour, and birth from pathological ones (Lazarus, 1994). The development of cesarean section is a good example of the obstetrical technology that has changed childbirth. Cesarean sections have considerably increased in the last three decades. In 1965, cesarean sections was 4.5 per 100 deliveries in the United States, whereas in 1991, the rate was 23.5 cesarean sections per 100 deliveries (Lazarus, 1994).

During the second half of the 20th century, particularly in the 1960s and 1970s, various models of childbirth were proposed in response to the over-medicalization of birth. These models included alternatives, such as: home births, midwife-attended births, Lamaze's techniques, husband-coached births, and water

births (Armstrong, 2000). All these alternative efforts sought to empower women to take responsibility for the outcome of their birth, as well as the management of their childbirth pain. They also aimed at helping women control their fear of a normal childbirth (Enkin, 2000). In spite of these alternative methods which have been clearly suggested for over a century, pregnancy and birth continues to be a medicalized process. In north America, between the mid-1960s and the late 1980s, the cesarean section rate has increased fourfold (Cunningham & Williams, 2005).

Nowadays, childbirth is seen as a hospital-based event in American society, and obstetricians have taken increasing responsibility for both normal, and births with complications (Armstrong, 2000). Moreover, American women have become convinced that the various technologies that are offered to them throughout their pregnancy and labour, make these better and safer, as well (Beckett, 2005; Hausman, 2005). Women fear the birth process. This fear is a consequence of American society's efforts to dominate and control nature. Women look for obstetric intervention in order that they can be safe, and feel safe for their babies, and they do this by undergoing more technological procedures, such as cesarean sections (Beckett, 2005; Davis-Floyd, 1994).

On the other hand, in the early 1970s, the feminist movement began to argue that many of the routine obstetrical interventions, such as epidural anesthesia were not evidence-based, and not only had no benefit, but were also harmful for the mother and child (Clakson & Newton, 2001; Thorpe, et al., 1993). In spite of the feminist activists' demand for more "natural" births, most hospitals continue the use of highly technological interventions. Cesarean section rates are a symbol of technological use during birth, and these have risen by 26% in Canada and 29.1% in the United States (CIHI, 2007). Most hospitals use routine EFM on labouring women, and epidural analgesia and induction of labour are widely administered. In Canadian hospital settings, the lithotomy position is the most

commonly used position for (CPSS, 2008). Hospitals nowadays label most women as high-risk cases. Hausman mentioned in his 2005 study that: “risk is a defining concept of medicalized childbirth” and resulted in more interventions at birth (Hausman, 2005). She believed that the ‘risky business’ of childbirth considers pregnancy as an illness that should be controlled by the specialization of obstetricians. Due to this, the opportunity of giving birth normally is becoming rare in many hospitals in the United States and everywhere else (Hausman, 2005).

1.2. A Brief History of Birth in Quebec

In Quebec, before the 1960s, most women underwent childbirth at home, whilst accompanied by a traditional midwife, or even with the help of relatives, and family members. However, by the end of the 1960s and 1970s, childbirth practices shifted toward the hospitals where routine preparations for birth including prenatal shaves, enemas, repeated vaginal exams, etc, were an inseparable part of care during labour. Most of these hospital procedures were in conflict with hospital policy, and were not directly related to the birth experience itself (Laurendeau, 1987; Vadeboncoeur, 2004).

In 1980, about 10,000 women participated in a regional conference, titled: “Accoucher ou se faire Accoucher” in French means “to give birth or to be delivered” to question the changing birth practices in Quebec (ASPQ, 1980). During the 1980s, birth practices started to change. In 1990, the adoption of “Bill 4” authorized the experimentation of midwifery practice in eight birth centers (P.L.4., 1990), a move towards humanizing childbirth. The aims of the evaluation of the midwifery pilot projects in Quebec were, among others, to compare midwives' services to physicians’ with regard to maternal and neonatal mortality

and morbidity, the use of obstetrical intervention, individualization and continuity of care. The study revealed many favorable findings for midwifery practice, such as a reduction in unnecessary medical interventions (Blais & Joubert, 2000). In 1993, a few midwives were permitted to work as independent professionals in these birth centers. Maternity wards were renovated to make them more convenient for women, as well as decrease certain medical interventions. There have been other progresses achieved towards the humanization of birth (Vadeboncoeur, 2004). The rate of episiotomies decreased from 57% in 1991-1992 to 32% in 1999-2000, and the utilization of forceps and vacuum extraction has decreased from 21% in 1982-1983, to 16.1% by 2000-2001 (MSSS, 2000-2001).

So, finally, in 1999, after twenty years of struggle, the midwifery profession became legal (Pascal, 2000). Since then, the sanction of the new law, Bill 28 (1999; chapter 24), has permitted midwives to work in hospital centers, birth centers, and even to carry out home births (Database, 2006). Did this movement make childbirth into a humanized event by the end of 20th and beginning the 21st century for Quebec? There are still eleven birth centers with midwife attendants in Quebec and each carries a maximum of 300 births per year (OSFQ, 2010).

Even if there are a few hospital centers which are equipped with different facilitators (such as whirlpools, birth balls, and massage chairs), the utilization of these facilities are rare (Harrison, Kushner, Benzies, Rempel, & Kimak, 2003). According to the Ministry of Health of Quebec (MSSS, 2000-2001), 99.7% of births take place in hospitals, compared to 0.2% home births in Quebec (Canada, 2003; MSSS, 2000-2001). In 2008, obstetricians also attended about 67.2% of births, while midwives, in Quebec, attended only 2.6% of all births (Dzakpasu, et al., 2008).

Even though the rate of some assisted deliveries, such as vacuum extraction, and primary cesarean section have decreased recently (CIHI, 2007, 2010), the rates of other medical and surgical interventions including the administration of epidural analgesia, and caesarean section are at their highest levels. The epidural rate in Quebec increased from 21.1% in 1983 to 50% in 2000-2001, and reached to 69% in 2008-2009 (CIHI, 2010). The findings showed a higher use of selected interventions in pregnancy, labour and birth than what are recommended by World Health Organization.(Dzakpasu, et al., 2008) A Canadian Perinatal Survey (Dzakpasu, et al., 2008) showed that cesarean births (26.3%) and epidural analgesia (57.3%) were the frequent procedures at birth in 2006 -2007. About 90.8% of women reported having electronic fetal monitoring (EFM) during labour, and 62.9% reported having continuous use of EFM.

1.3. Definition of Medicalization, and the Technocratic Model of Birth

Medicalization at childbirth refers to processes by which non-medical and physiological processes of birth become and are treated as medical problems, usually in terms of a risky situation (Hausman, 2005). The medical management of labour and birth - e.g., the use of ultrasound, EFM, oxytocin, and instrumental and surgical deliveries have changed the portrait of childbirth in most countries, particularly in America. The medical view of birth intergrates the concepts of biology and technology together, in order to create the *biomedical model* of birth. This model implies that birth must be managed by advanced technologies, (R Davis-Floyd, 1994) because “technology and medicine are inextricably linked” (Henley- Einion, 2009). Henley-Einion (2009) argued about how advances in technology within societies have changed women’s perceptions of pregnancy,

childbirth, motherhood, and obstetric technology, and how they have now become an integral part of normal birth (Henley- Einion, 2009). The use of technology is supposed to provide the mother with more safety and assurance, but rather, it seems to have replaced the giving of emotional support by humans (Bassett, Iyer, & Kazanjian, 2000). Studies carried out regarding the childbirth experience have shown that the over-medicalization of birth in normal and uncomplicated pregnancies leads to the absence of privacy, less attention being paid to the labouring women, and less respect for their dignity and human rights (Khayat, 2000; Miller, Cordero, & Coleman, 2003).

Since the 1900s in the USA, birth is a phenomenon that has been increasingly conducted under a set of beliefs and paradigms, which together are known as the *technocratic model* of birth (Davis-Floyd, 2001). This model implies an ideology of technological progress which sees it as a source of political power (Reynolds, 1991). In the technocratic model of care, the woman's body is seen to operate as a machine. The physician becomes a technician or a mechanic to come up with a technical solution in order to solve the technical problem (Davis-Floyd, 2001). Hospital-based deliveries are clear symbols of the technocratic model of birth, since they are processes whereby a variety of "standard procedures" and interventions, as well as the use of machinery and technology are offered to the women supposedly aiming to provide a safer birth. This is done even though the benefits of such procedures are doubtful (Henley- Einion, 2009; Jordan & Davis-Floyd, 1993; Rothman, 1989).

The technocratic model of care was described by Davis-Floyd as a model in which there was a division of the mind and the body. That model considers the body as a machine which in turn yields authority and responsibility to the practitioner, not the patient. It involves valuing science and technology more than

what it should be valued, and providing aggressive intervention with an emphasis on short-term findings, as well as seeing only death as defeat (Davis-Floyd, 2001).

1.4. Definition of the Humanization of Birth

The concept of humanized care is one, which has been growing steadily around the world. The literature reveals different perspectives on the concept of the humanization of birth. From previous literature, we have come to the understanding that the humanization of birth does not remain restricted only to technical attributes, nor does it simply refer to providing care for women in a humane manner (Jones, 2002). According to Lindsay, the aforementioned concept is not limited to just normal pregnancies. The optimum care for high-risk pregnancies is not either restricted to just precise monitoring or medical intervention (Lindsay, 2006). The concept of the humanization of birth includes the capacity to understand, as well as to respect human beings in the different forms of their existence (Backes, Koerich, & A. Erdmann, 2007). This concept also aids in the provision of physical and emotional privacy, and preparation of a comfortable environment for the women during the prenatal care period (Kuo, 2005).

Moura (2007) revealed that humanized assistance during childbirth privileges respect towards women's sense of dignity and autonomy, while reinforcing their active role in the birth process (Moura, et al., 2007). The over use of obstetric interventions and technology not only has shown to be harmful for mother and baby, but also has the potential of removing women from the center of their experience and leading the birth attendant who uses the intervention to take control of the birth process. As a result, women become more disempowered, view their bodies and their healthcare decisions through the lens of medicine. Their

choices are influenced by what is considered acceptable by the majority in society (Roland-Schwartz, 2007).

Reducing over-medicalized childbirths, and advocating for humanized birth practice seems to benefit from a philosophy based on women's empowerment, and women-centred care. Women believing that their bodies are naturally made to give birth can lead to minimal intervention, as well as a decreased use of technology (Brunt, 2005). The use of an evidence-based maternity practice is another advocate of humanized birth care (Umenai & Wagner, 2001).

In his famous article: "*fish can't see water"*, Wagner (2001) stated, "humanizing birth means understanding that the woman giving birth is a human being, not a machine". In the humanized birth model, the woman is in control of her own birthing, and thus she makes all the decisions regarding what happens to her and her baby. Wagner believed that women should have the right to commit errors during their birthing, and that they alone should be responsible for their mistakes, not anyone else (Umenai & Wagner, 2001).

Some aspects of the humanized birth model were presented in a report by the British Government in 1993 (DOH, 1993). These were based on the following three key principles:

1) Women must feel that they are at the centre of maternity care to make decisions, to have control over their labour, and to have discussed matters with their health care providers.

2) Maternity services must respond to mother's needs. They should be effective and easily accessible.

3) Women should be involved in maternity services planning in order to ensure that they are tailored to the needs of women in society (Page, 2000).

In the Misago et al (2001) study, the humanization of birth was defined by the following characteristics: 1) the fulfillment and empowerment of both women and their care providers; 2) the promotion of the active participation and decision-making by women in all aspects of their own care; 3) the provision of care by both physicians and non-physicians working together as equals; 4) the inclusion of the use of evidence-based technology; and 5) the location of birth attendants and institutions within the decentralized system with a high priority for community-based primary care (Misago, et al., 2001).

According to Davis-Floyd, the body and the mind are in constant communication, and it is impossible to treat the body's physical problems without also treating the mind (Davis-Floyd, 2001). The humanized childbirth practice persists on the emotional aspects of maternity care, such as continuous support during labour and delivery. It has been shown that paying attention to the psychological aspects of care might be a more effective strategy during labour than technological interventions (Hodnett, 2006).

One of the most important aspects of humanized birth is to be able to look at a pregnant woman as a person and not a patient, and to be able to establish a real human connection with her. The connection between the care provider and the woman is an important principle of the humanized birth approach (Davis-Floyd, 2001). The presence of doulas during labour, and the supportive role they provide, advocates for normal births and generally result in better maternal and neonatal outcomes as well as lowering the use of technology. This also leads to a reduction in the caesarean rate, a lower rate of analgesia use for pain relief and use of oxytocin, a decrease in the duration of labour, and an overall increase in maternal satisfaction regarding the birth experience (Bruggemann, Parpinelli, & Osis, 2005; Campbell & Rudisill, 2006).

Davis-Floyd (2001) argued that women should be more informed and that they should participate in the decision-making process as well as they need to fully understand their diagnosis and treatment. He argues that they should also be informed about the different options available for giving birth, as well as and that they should be made aware of the risks and benefits of each method (Davis-Floyd, 2001). Humanizing birth also allows women to feel empowered to discuss the choices of treatment which are available to them, rather than not having a choice at all (Harrison, et al., 2003).

1.5. Humanizing High-Risk Pregnancy

Humanized birth in a high-risk pregnancy is something that goes beyond curing women, however, a few studies have taken into consideration this concept in care provided to a high-risk pregnant woman.

Even though most women are expected to follow a normal and healthy pregnancy, 15-20% of all pregnancies are considered to be at 'high-risk' This means that the pregnancy may prove to be dangerous to the mother and/or the baby (Levy-Shiff, Lerman, Har-Even, & Hod, 2002). The risk factors observed are usually biomedical factors, and generally relate to the women's previous, or present medical or obstetrical history (Lindsay, 2006). Nevertheless, Hausman (2005) argued that there is no distinction between "low" and "high" risk in pregnancy, as no pregnant woman exists without some risk. Many of the at risk women are unlikely to turn to high-risk levels, while low risk women can always pass through risky situations.

According to Hausman, "risk is a defining concept of medicalized childbirth" (Hausman, 2005). It means that the potential for negative

consequences of a pregnancy or 'risk' has significantly impacted the medical and technological practices of obstetricians and healthcare decisions that pregnant women make (Roland-Schwartz, 2007). The concept of risk has had a large influence on American culture, as well as on social behavior. This can be one of the most important reasons for the fear of pregnancy amongst amongst 20th century. American women (Leavitt, 1984). The medicalized birth model has created a medical understanding of the risks of childbirth (Davis-Floyd, 1992) and as the literature has pointed out: the medicalization of childbirth is *itself* the shift which has transformed danger into risk, and which implies an accompaniment of medical technology, monitoring, and intervention to birth (DeVries, 1984).

Most of the literature has focused on humanized birth in normal pregnancy but so far, fewer studies have specifically focused on humanized birth in high-risk pregnancy. Humanized birth is a versatile and promising process and can often offer some normality in the midst of a high obstetric risk situation (Behruzi, et al., 2010a). Lindsay indicated that humanized care was not restricted to normal pregnancies and the optimum care for high-risk pregnancies was not just limited to precise monitoring and medical intervention (Lindsay, 2006). On the other hand, previous research has shown that the humanization of birth in cases of high-risk pregnancy by no way opposes the use of technology alongside it (Behruzi, et al., 2010a).

High-risk patients can present a challenging experience for the care provider who is accustomed to caring for these women (Campbell & Rudisill, 2006). The human characteristic of care provided by health professionals in high-risk pregnancy cases seems to be a lesser concern than the provision of care toward a present *ailment during* pregnancy, such as diabetes, preeclampsia, and others. The characteristics of a high-risk pregnancy are described as *anxiety* and conditions *uncertainty*. Women undergoing a high-risk situation have more

difficulty coping with their diagnosis (Clauson, 1996; Yali & Lobel, 1999) and thus the humanization of care in high-risk pregnancy cases should go beyond simply curing women of their illness. Sittner (2005) argued that in order to *implement* effective nursing care for high-risk women, nurses need to also have a thorough understanding of women's feelings of the situation (Sittner, DeFrain, & Hudson, 2005).

Lindsay (2006) emphasized that most women who are faced with a high-risk pregnancy need support as well as continuing information about the process they are experiencing (Lindsay, 2006). Labeling a pregnancy as 'high-risk' makes the women whom it affects psychologically sensible, vulnerable, and powerless (Lindsay, 2006). The key strategy to the humanization of birth in high-risk pregnancy is providing strong emotional and psychological support for the women by facilitating communication between them and their family (Harrison, et al., 2003; Lindsay, 2006; Martin-Arafeh, Watson, & Baird, 1999; Richter, Parkes, & Chaw-Kant, 2007; Soeffner & Hart, 1998). In her article, Lindsay introduced an approach of humanized management of birth in high-risk pregnancies. This approach emphasizes promoting the mother's psychological and physical well-being, giving her confidence in her abilities as a woman and as a mother in identifying her personal perception of risk, coping mechanisms, and exploring her personal feelings about her baby, as well. This method also aimed at providing continuity of care and support during pregnancy, and all the way into the postnatal period. This is hopefully a way to provide an opportunity for the women to reflect on their experiences after the birth (Lindsay, 2006).

Finally, from the previous literature we do understand that the humanization of birth at high-risk pregnancy is an approach which might also help parents cope with the pain and deep sorrow associated with the sudden loss of a baby (Davis-Floyd, 2001). Thinking of the concept of death can serve as a good

starting point when thinking about introducing the humanized birth approach into high-risk pregnancy (Behruzi, et al., 2010a). Care and compassion towards women should be a normal responsibility of health providers when they face suffering women who might have lost their baby (Behruzi, et al., 2010a). In the context of the humanization of birth, however, death is considered as an acceptable outcome (Davis-Floyd, 2001).

1.6. Feminist's Views on the Concepts of Choice and Control

Although the use of technology can save a woman during a high-risk situation, its application during normal pregnancy and childbirth has led to the disempowerment of women, whilst seemingly enabling them to achieve a safer, and more pleasant birth experience (Klima, 2001). Women have begun to believe that care providers are better informed about their physical conditions, and have therefore become dependent on what they are told (Bluff & Holloway, 1994; Duden, 1993). The literature shows that women's perceptions of the health care professionals as 'experts' places the care providers in a position of authority where they must take control and make decisions for the pregnant and/or labouring woman. Consequently, we see that the more technology is used, the less control a woman has (Schneider, 2002).

Feminist literature has argued that through the emergence of obstetrical care, and the use of common interventions in birth practices, birth has become a medical event which has opened a door to modern obstetric technology and which in turn allows it to control and manage birth as if it was an abnormal situation (Beckett, 2005; Rothman, 1982). The power of obstetricians over birth, and the struggle for control of the birth place were two important issues which helped provoke the feminist movement (Jordan & Davis-Floyd, 1993; Lazarus, 1994; Rothman, 1982).The essential part of this movement consisted of the fight for

women's rights to have control over their own bodies. Feminists believe that women should pay close attention to their bodies' alarms and signals rather than the signals of monitors and the findings of medical exam tests. They suggest that women should trust their psychological resources and also innate natural techniques, such as relaxing and breathing deeply, in order to control their pain during pregnancy and labour (Martin, et al., 2003). They also argued that the medicalization of birth takes control of women's bodies, thus forcing them to adapt to institutional rules (Martin, et al., 2003; Rothman, 1982).

While feminist activists argued about the medicalization of birth, and women's loss of control and empowerment over their own births in recent years, the feminist literature has begun to uncover women's own views of the medicalized birth model (Davis-Floyd, 1992; Fox & Worts, 1999; Martin, 1992; Rothman, 1982). The literature has shown that women's *own* desire for the medical model of birth, and among them "epidural analgesia", is a great factor which acts towards its implementation (Davis-Floyd, 1992; Dillaway & Brubaker, 2006; Fox & Worts, 1999). Davis- Floyd's (1992) study showed that seventy percent of interviewed women were both excited and comfortable with their highly technocratic childbirth experience (Davis-Floyd, 1994). Lazarus' study showed that women participants expressed an acceptance of the medical view of birth to a degree, as well as concluding that women's concerns about safety made them feel better in a hospital environment (Lazarus, 1994). It seems that the medicalized birth model is so embedded in the American culture that women are less likely to question the use of any particular procedure in the hospitals (Dillaway & Brubaker, 2006). Davis-Floyd's study also showed that the medicalization of birth is seen by the American middle class as a means of gaining "control and empowerment" over birth, rather than as a system of loss of autonomy and control (Davis-Floyd, 1994). Women's medical perspectives themselves help the authorization of the use of more advanced medical technology

during birth. Some research has shown that women's choice to receive medical intervention makes them feel more empowered, and as if they are 'in control' (Cindoglu & Sayan-Cengiz, 2010; Davis-Floyd, 1994, 2001).

Women's rights to choose their birth place, the care provider who assists in the birth, and the condition in which they would prefer to give birth is also an important factor which has been stressed in feminist literature (Beckett, 2005). The literature shows that women's choice and demand for obstetric technology is an important factor in the increasing caesarean-section and epidural analgesia rates in birth (Beckett, 2005; Béhague, Victora, & Fernado, 2002; Cindoglu & Sayan-Cengiz, 2010). However, it is clear that feminist activists cannot debate choices that women have actively made as the choice to undergo medical interventions, such as epidural analgesia or caesarean section.

While the first wave of feminist activists defended women's rights to pain relief procedures during childbirth, a second wave of feminists struggled for women's rights to choose non-medicalized or 'natural' births (Beckett, 2005). Nevertheless, a third wave of feminists has criticised the rejection of pain relief as an unrealistic behaviour (Shapiro, 1998), arguing the fact that: "it is interesting that a supposedly feminist movement is the very same that insists on women feeling pain" (Shapiro, 1998). This third wave of feminists argue that the use of obstetric technology during pregnancy and birth is not necessarily in opposition with women's interests, and that many women seek to minimize the pain of childbirth through these methods (Beckett, 2005). Freiman (2000) argued that women can meaningfully choose and benefit from obstetric technology for many reasons which might be important to them (Freiman, 2000).

Much of the feminist literature has shown that women do not obtain accurate information regarding the risks and benefits associated with the medical

interventions they receive. This is due to the fact that this information is prepared based on the hospital, or the physicians' interest, convenience, and/or profitability, rather than on women's interests (Beckett, 2005; Henley- Einion, 2009). A true choice, therefore, is not offered in these cases and women choose medical interventions, such as epidural analgesia and caesarean section for their first pregnancy without fully understanding the side effects or consequences of these interventions (Henley- Einion, 2009).

In spite of the feminists' endeavours to establish normality in the birth practice, a persisting philosophy which views birth as a pathological event, is a dominant factor of impact on childbirth practices in American society likewise in other countries (Klima, 2001). Obstetricians in America also defend the high rate of surgical birth on demand and argue that women should be respected in their choices and preferences (ACOG, 2003).

1.7. Women-centered Care and Empowerment

Women-centered care clearly implies that the primary focus of this kind of care is based on women's experiences, their expectations and their needs. It is a dynamic process that provides a safe, skilled, and individualized kind of care during pregnancy (Midmer, 1992). The philosophy of women-centered care in birth practices consists of shifting the birth practice from being a technological process to being a more personalized one, as well as changing the views of birth as being a biomedical event towards seeing it as a normal developmental task (Midmer, 1992). This approach is also based on the belief that childbirth is an autonomous and independent life event in a woman's life. It focuses on the emotional and psychological needs of the childbearing woman (Skinner & Roch, 1995).

The issue of power is another important occupational theme seen in women-centered care, and it refers to a structure where the power is governed by the woman's side (Midmer, 1992). Maputle (2004) introduced a theoretical framework for women-centered care. The essential components of her framework included: mutual participation and responsibility sharing between women and professionals; information sharing and empowerment; interdependence and collaboration; participative decision-making; open communication and listening; respect and accommodative midwifery action; self-determination, self-reliance; and maximization of the human and material infrastructure (Maputle, 2004). Having access to information is considered a woman's right that allows them to make informed choices (Skinner & Roch, 1995).

The empowerment of women in the birth setting is an important pre-requisite in the achievement of women-centered care, and it implies "giving authority to women" (Hornby, Wehmeier, & Ashby, 2000). In health care services, this concept can be defined as "having a say in the planning of care, and providing women with the appropriate support, information, and advocacy" (Elisheva, 1997). This voice is one of the most important factors involved in the outcome of the decision making process. It creates a sense of the worth of each individual and allows them to use their sociopolitical decision-making skills to participate in influencing the environment (Kieffer, 1984).

One of the most empowering and life changing events that a woman can experience in her life is giving birth normally. Because of the feeling of dis-empowerment, and a lack of confidence, as well as a lack of exact information, women's desires for a normal birth have changed all around the world. Women's disempowerment leads to an increase in their fear of a normal birth (Nilsson & Lundgren, 2009); and consequently, it allows for more medical intervention at birth (Carlton, Callister, & Stoneman, 2005). Empowering women seems to be a

key strategy for the reduction of maternal mortality as it helps women trust their bodies, allowing them to experience the joys of a normal birth. Empowering women also in turn enables them to make decisions, and take responsibility for their health as well as their baby's, while at the same time allowing them to be able to demand quality health care for themselves, their families, and their community. Women who feel empowered can trust their body's ability to give birth without an excessive demand for any medical intervention (Carlton, et al., 2005). Parsons has categorized the most important criteria for the empowerment of women as: 1) having one's voice be amplified, 2) being respected, 3) having an advocate, and making one's own decisions; and 4) being able to take risks (Parsons, 2001).

1.8. Women's Satisfaction of Childbirth

The literature shows that women's satisfaction with their labour experience depends significantly on their feelings of control (Knapp, 1996), feelings of accomplishment, and general emotional well-being during the postnatal period (Gibbins & Thomson, 2001; Green & Baston, 2003). Women can experience pain and control in different ways, both positively and negatively, but they always feel better when their baby is healthy (Halldorsdottir & Karlsdottir, 1996).

Postpartum support also appears to have a positive influence on the childbirth experience. 'Support' was generally described by women as being caring, providing emotional support, and having a presence (MacKinnon, McIntyre, & Quance, 2005). The literature shows that the presence of a supportive and knowledgeable care giver, who communicates information accurately during labour and involves women in the decision-making process, can enhance women's satisfaction with the childbirth experience as well as enhancing a feeling of control

in women (Brown & Lumley, 1998; Corbett & Callister, 2000; Green, Coupland, & Kitzinger, 1990; MacKinnon, et al., 2005; Waldenstrom, Borg, Olsson, Skold, & Wall, 1996).

Labour pain has been discovered to have a mostly negative impact on women's birth experiences and satisfaction (Lavender, Walkinshaw, & Walton, 1999; Slade, MacPherson, Hume, & Maresh, 1993). However, some women experience a feeling of accomplishment after coping with the pain which is an important feeling during the transition into motherhood (Lundgren, 2004; McCrea & Wright, 1999; Salmon, Miller, & Drew, 1990; Waldenstrom, et al., 1996). Previous research by Teixeira and her colleague uncovered women's dissatisfaction with the childbirth experience in hospitals in Brazil, where the principles of the humanization of birth practices have been implemented by Minister of Health. In those hospitals, the women were treated in an environment based on violence and disrespect (Teixeira & Pereira, 2006).

2. PREVIOUS RESEARCH ON CHILDBIRTH

In the following section, some past studies, which have focused on the humanization of care in normal and high-risk pregnancies, are presented.

2.1. Humanizing Birth Practices in High-risk Pregnancies

A study on high-risk pregnancies conducted by Ritcher (2007) included thirteen high-risk women who were hospitalized in the high-risk ante-partum unit of a large tertiary hospital in Edmonton, Alberta. A qualitative descriptive design was used. Ten patients participated in individual interviews and three participated in a focus group. The findings of this study showed that women felt a loss of

control in these situations and had the feeling of being a burden. These women needed more privacy, more family-centered care and more activities in order to relieve the boredom (Richter, et al., 2007).

In a previous research conducted on the concept of the humanization of birth in high-risk pregnancies by Behruzi et al (2010) in 2008, twenty-one midwives, obstetricians, and health administrator professionals from different clinical and academic fields were interviewed in nine different sites in Japan. The professional interviewees believed that the stressful nature of high obstetric risk pregnancies and the emergence of the utilization of more obstetrical technologies to cure the associated problems did not leave much room for the psychological care of the patient. The authors concluded that the fact that intervention can sometimes be life-saving, does not logically imply that healthcare providers cannot apply the humanized birth and psychological care approaches during high obstetric-risk cases (Behruzi, et al., 2010a)

An ethnographic study by Heaman (1998) was conducted on a sample of twenty-four high-risk pregnant women who had been on bed rest for at least seven days in a tertiary hospital. The study aimed at comparing perceptions of women cared for in the home with those in hospital. Participants were recruited from the antepartum unit of a tertiary care hospital and from an antepartum home care program in Western Canada. Data were collected in 1994 through interviews and participant diaries. Using content analysis for their study, they showed that these women suffered from more stress, had a greater lack of privacy, and more hospital discomfort, sense of loneliness and boredom (Heaman & Gupton, 1998). Martin-Arafeh (1999) suggested some strategies which promoted family-centred care in high-risk pregnancy in order to enhance women's satisfaction of the received care. The author addressed a model of care that emphasized the family assistance to the

health care team in order to shift from the medical aspects of care “to one that was incorporated to include the woman's family” (Martin-Arafeh, et al., 1999).

2.2. Humanizing the Birth Practice in low risk Pregnancies

The humanization of birth and the quality of care provided to women during childbirth has been the subject of many studies during the last few decades.

In Quebec, for example, Vadenboncoeur (2004) carried out an ethnographic study to show how obstetrical practices had changed during the past two decades. The researcher in this study explored birth practices, in second level hospital settings in Quebec from a ‘humanization of birth’ point of view. The reason for choosing these hospitals for this case study was the researcher’s emphasis on having low levels of intervention being carried out in the hospitals. The methods of collecting data in this study consisted of observation of the participants’ obstetrical practice, and the observation of fifteen labours and births. Semi-structured individual interviews were also carried out with thirty of the participants, including health care providers, labour support women (doulas), birthing women, and a few of the women’s partners. The findings of this study showed that although there have been some positive changes towards the humanization of birth in hospitals compared to twenty-five years ago, birth practices had not yet been truly de-medicalized. This was observed while the women in the study were allowed to drink and walk around during labour, and no shaving and enemas had been seen at all. Moreover, the study highlighted the fact that most women at the time of the study, as in the 70s, still did not have a voice during labour and birth, and they did not have any informed choice regarding this issue. The researcher suggested that there was a need to conduct futuresearch on the concept of humanizing birth, particularly in more specialized hospitals, in

order to clarify what were the birth practices carried out in those hospitals (Vadeboncoeur, 2004).

A midwifery-practice evaluation was carried out in Quebec in order to compare the services provided by midwives and physicians in terms of humanization, women-centered care, and continuity of care among others. They asked a total of 933 midwives' clients and 1,000 physicians' clients to respond to a mailed questionnaire regarding the care they received. Women who received midwifery-care were generally more satisfied with the care they received during the prenatal, intrapartum, and postnatal periods. The findings showed that the mean score differences between the midwives' and physicians' clients were significant for all the tested indicators (t-test, $p< 0.001$). These findings strongly imply that these women received a more personalized and more humanized type of care. The authors of this paper also concluded that the data found in this study should be considered in future developments of the maternity care system in a way as to integrate midwives into the health care system, thus advocating for humanized birth (De Koninck, Blais, Joubert, & Gagnon, 2001).

Many previous studies have focused on the perceptions of women and health care professionals regarding the concept of humanized birth (Castro & Clapis, 2005; Vargens, Progianti, & da Silveira, 2008). The bulk of studies on the concept of humanization of birth come from Brazil. Sixteen obstetric- nurses working in a maternity unit in Sao Paulo, Brazil, participated in a qualitative study. Semi-structured interviews were conducted. The findings showed that the nurses believed that "the humanization process has come about as a political strategy that aims to improve care, as well as rescuing natural births" (Castro & Clapis, 2005). Vargens et al (2008) aimed at analyzing the process through which nurse-midwives have given meaning to un-medicalized care. A qualitative study based on the Grounded Theory was done in Brazil in 2006. Eight nurse-midwives

were interviewed. The humanization of birth was perceived as a form of respect for human physiology and as a consequence, prevention of unnecessary routine medical intervention during birth (Vargens, et al., 2008).

An exploratory research was also carried out to determine the perspectives of managers on the implementation of the humanized birth care approach in Rio de Janeiro. The researchers interviewed six coordinators and managers of eight municipal maternities. This study showed that the managers' main strategies were focused on: 1) the quality of interpersonal relationships between professionals and users; 2) the recognition of patient's rights; 3) the democratization of power relations between professionals and patients; 4) the non-medical view of labour and birth; 5) the promotion of a relationship between the family, the mother, and the newborn in hospital; and 6) the valuation of health professionals (Deslandes, 2005). The pregnant women's experience of childbirth in public maternity hospitals in Rio de Janeiro, Brazil, did not, however, quite meet the proposed humanized birth care model set by the municipal health policy. The concept of the humanization of birth was unknown to the women interviewed. The possibility of having a companion was the only facilitator for humanized birth care observed and the women still did not have the possibility of an informed choice (Dias & Deslandes, 2006).

Tornquist's (2003) study was carried out in the maternity ward of a university hospital in Santa Catarina, Brazil, where the World Health Organization's (WHO) guidelines for humanized birth care were implemented. These included the reduction of excessive technological intervention in birth, natural breastfeeding, rooming-in, and extended family visitation. The implementation of WHO guidelines showed significant success in promoting this kind of care. However, challenges continue to rise in ensuring that this philosophy

is adhered to by the professionals and students in the institutions (Santos & Siebert, 2001; Tornquist, 2003)

There exists a great amount of literature on the concept of the humanization of birth in Brazil. Misago et al carried out a survey in 2001, which aimed at changing childbirth practices in Brazilian hospitals from a medicalization-centered practice, to a humanized one. The humanization of birth was also implemented in five municipalities in the State of Ceara (Brazil), with the collaboration of the Japanese International Cooperation Agency, and the Maternal and Child Health Improvement Project in North-East Brazil. The implementation of humanized childbirth focuses on training-based intervention activities which include: seminars, workshops, in-service training, and teaching humanized maternity care to the participants themselves. Humanizing birth was defined as a "safe and satisfying birthing experience" in this study. A self-inclusive experimental study which was based on a before and after design, was also used to compare birth practice situations. A rapid anthropological assessment procedure was carried out to collect the data, and a total of 279 interviews, and 348 observations, were carried out between 1997 and 2000. The findings showed an observable change from a culture of dehumanized birth practices, to one with a humanized birth approach. Women who had been unattended in previous years were always accompanied during labour, and had a doula present when a family member was not available. The labour rooms were more comfortable, and women were allowed to choose the posture they preferred during birth. There was also an observable change in the inter-personal relationships as well as team work among the health professionals who received the humanization of childbirth training (Misago, et al., 2001). It was also interesting to note that more women began wanting to deliver in these hospitals after this implementation, and that the rate of delivery in these hospitals escalated from thirty, to a hundred deliveries per month (Misago, et al., 2001).

The quality of care and the provision of humanized birth in the hospitals were subjects of many previous studies. Miller et al (2003) conducted a study about the quality of care in the Dominican Republic. A multidisciplinary team conducted a comprehensive survey in order to evaluate the birth practices in fourteen individual hospital centres in the Dominican Republic where forty percent of all births took place. The findings of this study have shown that the medicalization of birth in normal and uncomplicated pregnancies, as well as complicated pregnancies, was not appropriately managed. In all the hospitals studied, low quality of care was observed, and the labor and delivery birth care processes were not humanized. In these hospitals, women laboured alone, unaccompanied by family, and were not informed about the examinations that were given to them. The labour wards were too noisy, there was no privacy, and little attention was paid to the labouring women. There was no respect for dignity, and no attempt to honour human rights (Miller, et al., 2003).

Studying hospital practices in Lebanon was the topic of another research study carried out with the aim to acquire basic data on the routines and practices that play a role in the maternity wards of hospitals for women with normal deliveries. This was done in order to estimate the frequency of certain practices in this setting, as well as showing whether women were given choices during birth, and how much they contributed to the decision-making process. A total of 39 hospitals were selected for this study, and the methodology of research consisted of an observation check-list, and a semi-structured questionnaire. The directors, the head midwives and nurses, and the head of the department of obstetrics were interviewed. The findings of this study showed that efforts to improve maternity care in Lebanon, in fact resulted in an *increasing* use of technology, and the over-medicalization of birth practices in hospitals. Women in this country were rarely

given choices, and often did not know what was actually happening to them (Khayat, 2000).

Considering the literature, the humanization of birth care considers women and their needs to be at the center of maternity care, and tries to provide opportunities which in turn enable women to make decisions, practice their choices, and feel that they have control over their bodies while at the same time, exercising their right to have access to quality prenatal and continuing care. From the findings of the selected studies, one can conclude that the humanization of birth practices in hospitals have brought more satisfaction to women and their families by providing continuity of care, women participating in the decision making process, and providing emotional and psychological support to them. The humanization of birth aims at the reduction of excessive technological intervention at birth and unnecessary interventions, such as enemas, shaving, routine episiotomy and others. Nevertheless, the birth practices have not yet been de-medicalized. Moreover, the findings of studies highlighted the fact that women were still not informed of their choices regarding their childbirth.

2.3. Obstetrical Intervention in Birth Practices

Having a normal pregnancy and childbirth is an ultimate wish for every pregnant woman, but approximately one third of women need some kind of medical intervention to help the birth of the baby. The medical interventions used during childbirth include induction, electrical foetal monitoring, epidural analgesia, augmentation, episiotomy, forceps delivery, vacuum delivery and caesarean section. The appropriate use of these medical interventions clearly save the life of mothers and babies, however, there are some concerns that medical

intervention rates have been raised around the world, which suggests that they are not always necessary.

Researchers have tried to determine whether recent increases in the primary caesarean rate have been due to either maternal characteristics, or obstetric practice changes. A total of 12,564 women have recently contributed to a Canadian study in the province of Nova Scotia. Data from a population-based perinatal database were used to examine changes in maternal age, parity, smoking, pre-pregnancy weight, delivery weight and pregnancy weight gain among all deliveries between 1988 and 2001. Logistic regression was used to study the effect of changes in maternal characteristics and obstetric practice on primary cesarean delivery rates. The findings have shown that the recent increase in the cesarean section rates were in fact due to changes in maternal characteristics which included: age, parity, pre-pregnancy weight, and weight gain during pregnancy. However, obstetric practices, such as labour induction, epidural anesthesia, lower forceps use, and obstetrician delivery, have also heavily contributed to the increase in primary cesarean section rates (Green & Baston, 2003).

Janssen et al's study (Janssen, Klein, & Soolsma, 2001) aimed to compare cesarean delivery rates for low-risk nulliparous women in a community hospital and a tertiary hospital and to determine factors influencing those rates. A retrospective cohort study was done on 857 women who did not have obstetric risk factors. Researchers found that the odds ratio for cesarean sections in tertiary hospitals was 3.4, compared to community hospitals (95% confidence interval, 2.1-5.4). The reason for this difference was due to the different methods of these hospitals of attending labour and birth. The health care providers in the community hospital used a range of methods for pain relief as well as implementing a philosophy of keeping birth normal, while in tertiary hospitals, epidural analgesia was administered immediately after a woman's demand for

pain relief, which in turn influenced the normal progress of labour. Noticeably, the result of two recent meta-analyses carried out in Canada, did not show an increased rate of cesarean delivery in nulliparous women who received epidural analgesia (OR1.00–1.04; 95% CI,0.71–1.48) (Liu & Sia, 2004; Sharma, Mcintire, Wiley, & Leveno, 2004).

Women's demand for cesarean sections appeared to be an important factor in the increase of cesarean section rates in recent years in Canada, as well as in other countries (Anderson, 2004; Bergeron, 2007; Liamputtong, 2005; Morrison & MacKenzie, 2003). According to Béhague and colleagues (2002), Brazil had the second highest cesarean rate of twelve studied Latin American countries (55%), and their findings showed that women with higher education levels, as well as higher incomes, asked for more cesarean operations (45% and 50.0% respectively, $p< 0.001$) (Béhague, et al., 2002).

Most of the research which has been carried out on the subject of medicalized birth, focuses on the short-term medical outcomes of pregnancy (Hofmeyr, 2005). For example, reviews of ten trials have shown that continuous EFM during labour has been associated with reduced short-term neonatal convulsions, (RR 1.51, 95% CI, 0.32- 0.82), as well as with increases in cesarean sections (RR 1,41, 95%CI,1.23-1.61) and operative vaginal deliveries (RR 1.20, 95% CI,1.11-1.30), while long-term monitoring showed a trend of increased cerebral palsy cases, compared with the intermittent auscultation group [RR 1.66, 95%CI,0.92–3.0] (Thacker, Stroup, & Chang, 2004).

With the aim of decreasing the use of electronic fetal monitoring (EFM) in low risk women, Davies and colleagues (2002) carried out a study whereby they increased the provision of professional support to women in labour in both secondary and tertiary hospitals. In the studied secondary hospitals, the use of

EFM decreased from 90.1%, to 41.0% after the provision of support ($p < 0.001$); however, the nurses in this hospital observed no change in the provision of labour support. In the tertiary hospital, no change was observed in use of EFM, but there was a small, statistically significant increase in the time nurses spent providing labour support (23.5% to 29.8%, $p < 0.001$) (Barbara, Ellen, Mary, & Linda, 2002).

Amniotomies, and early oxytocin infusion, are the most routine methods used in the active management of labour. Sadler (Sadler, Davison, & McCowan, 2000) conducted a study in a tertiary referral obstetric unit in Auckland, New Zealand. A total of 651 women were randomly assigned to active management (n = 320) or to routine care (n = 331). It was found that active management of nulliparous labour *reduced* the duration of the first stage of labour (median 240 min vs 290 min; P = 0.02) , whilst not affecting the rate of caesarean sections (9.4% in active management compared with 9.7% for routine care) (Sadler, et al., 2000). A systematic Cochrane review consisted of eight trials on 4008 women showed that amniotomies were associated with an increased rate of caesarean delivery (crude OR 1.26; 95%CI 0.96–1) (5-minute Apgar score: < 7 (OR 0.54; 95%CI 0.30–0.96). The authors of this paper thus concluded that amniotomies should be restricted to women undergoing an abnormal labour (Fraser, Turcot, Krauss, & Brisson-Carrol, 2004). The induction of labour also increases the risk of giving birth to a baby that is pre-term or near- term -meaning the baby is born in the period between weeks 35 and 37. Wang et al (2004) carried out an analysis on the electronic medical record database of 7474 neonatal records and subset analyses of near-term (n = 120) and full-term (n = 125) neonatal records. Finding showed that the near-term infants were generally physiologically and developmentally less mature and thus, were at risk of ailments, such as temperature instability, hypoglycemia, respiratory distress, apnea, bradycardia, and clinical jaundice. Near-term infants had sepsis more frequently than full-term

infants (36.7% vs 12.6%; odds ratio: 3.97) (Wang, Dorer, Fleming, & Catlin, 2004). Sarici et al (2004) conducted a study on 219 term newborns (term group) and 146 near-term newborns (near-term group). Descriptive data analyses of data and the independent sample *t* and x^2 tests showed that the near-term babies often had problems feeding, and were subsequently 2.4 times more likely to experience an increase in the risk of hyperbilirubinemia (Sarici, et al., 2004).

Previous literature has shown that the administration of epidural analgesia can increase the cesarean rate. Liberman and Lang (1996) studied the association of epidural analgesia and cesarean delivery by a retrospective study of 1733 low-risk, term nulliparas, with singleton infants whose labour began spontaneously. An conducted. The finding of an adjusted logistic regression analysis showed that women receiving epidural analgesia were 3.7 times more likely to undergo a cesarean (95% confidence interval 2.4, 5.7). Interestingly, there was a more than two fold increase regardless of the dilation and station at administration of epidural analgesia (Lieberman & Lang, 1996).

Nevertheless, recent studies have found no statistically significant effects of epidural analgesia on the caesarean section rates (Anim-Somuah, et al., 2005; Michael Klein, 2006; Liu & Sia, 2004; Sharma, et al., 2004). A meta-analysis of seven randomised controlled trials by Liu and colleagues (2004) comparing low concentration epidural infusions with parenteral opioids showed that epidural analgesia did not seem to be associated with an increased risk of caesarean section (odds ratio 1.03, 95% confidence interval 0.71 to 1.48) but on the other hand, it might have been associated with an increased risk of instrumental vaginal delivery (2.11, 0.95 to 4.65) (Liu & Sia, 2004). In the Sharma et al study (2004), a total of 1,339 nulliparous women were randomized to receive epidural analgesia, and 1,364 women were randomized to receive intravenous Meperidine analgesia. The findings revealed that there was no difference in the rate of cesarean deliveries

between the two analgesia groups (epidural analgesia, 10.5% vs. intravenous meperidine analgesia, 10.3% ; adjusted odds ratio, 1.04; 95% confidence interval, 0.81-1.34; P = 0.920) (Sharma, et al., 2004).

Parry's study (2008) aimed to explore women's choice of midwifery, as well as their perceptions and experiences with medicalization. Eight women volunteered to participate in an interview. The findings of this study showed that Canadian women choose midwives in order to avoid the medical experience. The women participants criticized viewing and treating pregnancy like an illness rather than a natural event. Most of women remarked, "I didn't want all the medical intervention because I felt like being pregnant is not an illness" (Parry, 2008). Nevertheless, Macdonald (2001) argued that as the scope of midwifery has expanded in Canada, midwives nowadays use more medical technology in hospitals in order to both fulfill their professional obligations, as well as being able to respond to women's different choices (Macdonald, 2006). The medicalization of birth is even present in the practice of independent midwives in the Netherlands these days (Smeenk & ten Have, 2003).

Goldberg and colleagues conducted an interventional study to lower the rate of episiotomy through physician education in Philadelphia. The intervention consisted of an evidence-based recommending lecture. The data of three months prior to the intervention were compared to those of the year following. A multivariate logistic regression models was used. It was shown that for all vaginal deliveries, there was a decrease (17%) in the rate of episiotomy, from 46.9% to 38.8% (Goldberg , et al., 2006).

In 2008, a survey was conducted on women's childbirth experience, as well as medical interventions in birth practices by Public Health Agency of Canada's Canadian Perinatal Surveillance System (CPSS) in Canada. A

population of 8,244 birth mothers who were of 15 years of age and older with a singleton live birth was randomly selected. Of these women, 6,421 (78%) completed a 45-minute telephone interview at 5 to 14 months after the birth of their baby. The survey included more than 300 questions covering many aspects of perinatal care and interventions during pregnancy, labour and delivery. The findings revealed that almost one in five (19.1%) women with a vaginal birth or who attempted a vaginal birth reported a pubic or perineal shave, 5.4% had an enema, and 13.2% experienced pushing on the top of their abdomen to help push the baby down during vaginal birth. The findings showed that many of the medical interventions were routinely used without enough evidence of their effectiveness (CPSS, 2008).

2.4. Women's Experiences of Childbirth

The experience of labour and birth is considered mostly subjective and complex. Most of the research showed factors, such as care provider, control, continuity of care and support, decision making and pain were more influential than any other factor on the women's overall experience of childbirth.

A Canadian Perinatal Survey was conducted by the Public Health Agency of Canada's Canadian Perinatal Surveillance System (CPSS) aimed at examination of the experiences of Canadian women during pregnancy, birth and the early postpartum months. The mothers, who had an infant between 5 to 10 months, were invited to participate in a computer assisted telephone interview conducted by Statistics Canada. A sample of 6421 completed responses to the questions was randomly selected. Questionnaires included 300 questions covering a broad range of topics surrounding pregnancy, birth and postpartum. Interviews lasted 45 minutes. Findings showed that eighty percent of women were satisfied with the care they received during pregnancy, delivery and postpartum. The women attended by

midwives at birth reported their overall experience of labour and birth as “very positive” compared to those attended by other health care providers (Dzakpasu, et al., 2008).

Larkin et al’s (2009) literature review aimed to identify the core attributes of the labour and birth experience. A thematic analysis of a random sample of sixty-two papers published between 1990 and 2005 was carried out. This revealed the four main attributes of the experience as *individual, complex, process* and *life event*. The most frequently identified themes which related to the childbirth experience were also seen to be: *control, support, relationship with caregivers, and pain* (Larkin, Begley, & Devane, 2009).

Liamputtong’s (2005) study conducted in-depth interviews with forty-five Thai women in the cities of Chiang Mai, and Mae On. Results showed that the financial resources and education played a significant role in shaping women’s experience of birth throughout Northern Thailand. Moreover, they found that middle class women requested more medical technology as they considered it to be a way to have control over their birth (Liamputtong, 2005).

An important number of studies have addressed mothers’ satisfaction regarding the quality of birth practices. In two trials, the continuity of care by midwives was compared with the non-continuity of care by a combination of physicians and midwives. It was found that women who had received continuity of care, were less likely to request drugs for pain relief during labour (OR 0.53, 95% CI 0.44–0.64), episiotomies (OR 0.75, 95%CI 0.60–0.94). Their babies required less resuscitation (OR 0.66, 95% CI 0.52–0.83). However, these women had more f vaginal and perineal lacerations (OR 1.28, 95% CI 1.05–1.56). It is not clear though, whether the beneficial effects observed were due to the midwife-assisted care or to the increase in continuity of care (Hodnett, 2006).

Only a few studies examined mother's satisfaction with their involvement in the decision-making process during high-risk pregnancy. In Harrison et al.'s study (2003), 47 women with hypertension or threats of preterm delivery were interviewed after their deliveries in Canada. All the women had received prenatal care at home from nurses in community programs, or had been hospitalized. The data analysis showed that women generally had an increased feeling of responsibility for their baby's health, as well as their own. Nevertheless, they all differed in their choices between the active involvement or being passive in health care decisions. About fourteen of the women seemed satisfied with a passive involvement in the decision-making process (Harrison, et al., 2003).

The experience of pain and the strategies for coping with it vary among women. Some women desire pain relief with medication, while others wish to avoid medication. A Maternity Experiences Survey (MES) conducted by the Public Health Agency of Canada showed that methods of pain relief, such as breathing exercises (74.1%), changing positions (69.5%), baths or showers (54.8%) were the most frequent medication-free techniques for pain management in labour or birth. Epidural or spinal anesthesia was the medication-based technique most frequently used (57.3%). Most women (81.1%) who used this technique believed that it was 'very helpful'(CPSS, 2008).

According to the reviewed literature, the advocating role of the health care providers and especially of midwives and respect of women's needs are the two most important factors involved in the satisfaction of women during the childbearing process. All maternity care providers including physicians, midwives, and nurses can play an advocating role for mothers. They will thus enhance maternal satisfaction as well as clinical outcomes by providing appropriate information, establishing a good relationship, and ensuring continuity of care during birth.

2.5. Barriers and Opportunities Observed in the Changing of Birth Practices

This section presents some of the studies which identified the barriers and facilitators towards humanization of birth care as well as care assistance for a more humanized childbirth.

In Canada, as in many other countries, a number of specific organizations have been established with the philosophy of helping to improve normal births. Goer (Goer, 2004) carried out a survey of a convenience sample of 24 grassroots birth activist groups and sent them a brief questionnaire in order to explore the barriers and opportunities for the implementation of humanized birth in different parts of the world. The findings of this survey showed that the power held by physicians, brought about a resistance to change and prevented the introduction of evidence-based practices and humanized birth, by controlling policies, and by their control of the flow of information, as well as their monopoly on funding. Another large obstacle found was the lack of money in the institutions (Goer, 2004).

The Canadian Society of Obstetrics and Gynecology has recommended a decrease in the use of EFM by means of increasing the professional labour support offered during pregnancy. Graham et al. (Graham, Logan, Davies, & Nimrod, 2004) conducted a case study in order to explore the barriers and facilitators observed through the struggle to change the trend of the over-utilization of EFM in hospitals while evidence-based fetal health surveillance guidelines are applied. A qualitative case study was conducted at two tertiary and one community hospital. Data were collected through 14 focus groups with 51 nurses, followed by 8 interviews with nurse administrators and educators. Analysis of verbatim

transcripts and unit records, included coding and categorizing data, showed that to implement the best practice, “it is important to identify the organizational barriers present in the fulfillment of the change, which (in turn) require managing by the appropriate levels of administration in the organization”(Graham, et al., 2004).

With the aim of identifying the professionals’ perception of the potential obstacles and facilitating factors present in the implementation of humanized care in the case of high-risk pregnancies, twenty-one midwives, obstetricians, and health administrator professionals from the clinical and academic fields were interviewed in nine different sites in Japan from June through August of 2008. The barriers found in the provision of a humanized birth in high-risk pregnancies included factors, such as: 1) the pressure of being responsible for the safety of the mother and the foetus, 2) the lack of the women’s active involvement in the decision-making process, 3) the heavy burden of responsibility on the physician’s shoulders and potential legal issues, and finally 4) the lack of midwife authority in the provision of care for high-risk pregnancies. The facilitating factors found in the provision of a humanized birth in cases of high obstetric risk included: 1) the sharing of decision-making and other various responsibilities between the women and the physicians, 2) caring, 3) stress management, and 4) better communication and relationships between the health professionals and the patients (Behruzi, et al., 2010a).

Another study by Behruzi et al (2010) was carried out to explore the Japanese child birthing experience in various birth settings where the humanization of birth had already been implemented. The investigators explored the obstacles and facilitators encountered in the practice of humanized birth in those centers through a qualitative field research design (Behruzi, et al., 2010a). Twenty-five individuals from a multidisciplinary team of maternity care professionals, as well as nineteen labouring or postpartum women were

interviewed at nine distinct institutions. Data was collected through observation, field notes, focus groups, and informal, semi-structured interviews. A content analysis was performed. The findings showed that all the observed settings had implemented strategies which aimed at reducing caesarean sections, and keeping childbirth as natural as possible. The barriers and facilitators encountered in the practice of humanized birth were categorized into four main categories: 1) rules and strategies; 2) physical structure; 3) contingency factors; and 4) individual factors. The most important barriers identified in the system of humanized birth care were the institutional rules and strategies which restricted the presence of a birth companion. The main facilitators found for this purpose were: the women's own cultural values and beliefs in a natural birth, and the institutional strategies which had been designed to prevent unnecessary medical interventions (Behruzi, et al., 2010a).

The aim of Nagahama's (2008) study was to similarly identify the obstacles and facilitators present in the implementation of humanized care in two hospitals affiliated with the Unified National Health System in Maringá, Paraná, Brazil. A cross-sectional design was chosen together with analysis of the hospital patient's charts, and interviews. A total of 569 women who gave birth at these hospitals were interviewed from March 2005 to February 2006. The hospital-given care was characterized on the basis of four WHO quality-of-care guidelines for labour and delivery, which indicated it as follows: 1) providing adequate information to the women, 2) providing non-invasive and non-pharmacological methods of relieving pain, 3) presence of a companion during labour and delivery, and 4) early skin to skin contact with baby. The barriers observed in this study which prevented the implementation of the humanized model for childbirth care were: i) difficulties in the communications at the organization, ii) hospital protocols, and iii) the health professionals' individual practices and attitudes (Nagahama & Santiago, 2008).

Almeida's (2009) qualitative study focused on the evaluation of the program for the humanization of birth among Brazil's five geographic regions in 2003. Sixteen focus groups were formed with women in the primary care units. The analysis of data showed that women interviewed mainly expressed dissatisfaction with the care they had received during the prenatal period, as there existed in this period a lack of options regarding antenatal care services, a lack of accessibility to services -such as routine pregnancy tests and ultrasound-, and a lack of choice as to the location of the birth (Almeida & Tanaka, 2009). Moreover, the discrepancies and lack of flexibility in the care provided to the women damaged the bond which women established with their health providers, as well as creating obstacles for the active participation of the women in the services provided by the health care system. For example, the women were not able to participate in the puerperal consultation, as this consultation was not undertaken at any other moment to accommodate them (Almeida & Tanaka, 2009).

The other qualitative study by Castro and Clips (2005) aimed at identifying the obstetrical nurses perception of the humanization of childbirth, their birth practice, as well as exploring the factors that act as barriers in the implementation of this type of care. Semi-structural interviews were conducted with sixteen maternity nurses in the Sao Paulo, Brazil in 2002. The findings showed that nurses identify the concept of humanized birth as a process, rather than an event. The nurses mentioned that the humanization process is a political strategy for improving care, and rescuing normal births and that this process only occurs when women become active in labour and birth. The findings showed that nurses understand that the humanization process was characterized by the imposition of government policy, which aims to lower the rates of caesareans and improving care for women. They believe that this will occur if there is a paradigm shift, which includes women as key actors in the process. They also believed that

doctors were the biggest barrier for the implementation of humanized birth (Castro & Clapis, 2005).

In 1999, an observational study was carried out in four distinct hospitals in China in order to explore the country's clinical practices, women's preferences in these settings, and the provider's views towards birth practices. This study explored the barriers and opportunities present for the implementation of change in the hospital setting. It suggested that adjusting hospital policy would lead to making obstetric care more evidence-based, as well as more humanized (Qian, Smith, Liang, Liang, & Garner, 2006).

Kabakian-Khasholian's (2007) study aimed to analyze the environmental factors responsible for the rising of the caesarean section rate in Lebanon, and to reveal the possible approaches which could be adopted to decrease this rate . They analyzed attitudes, opinions, and actions of different stakeholders. Several semi-structured interviews were conducted and focus groups were established with a total of twenty stakeholders, and thirty-six women who had a cesarean section no more than four months before the study. The findings of this study illustrated many of the barriers encountered in shaping the current cesarean section practices. Among these barriers were the organization of the health care system, the dominance of the private sector, the lack of physician accountability, the minimization of midwives' roles in this process, and women's fallacious beliefs that cesarean sections provide a safer and easier way of giving birth (Kabakian-Khasholian, Kaddour, Dejong, Shayboub, & Nassar, 2007).

In conclusion, by reviewing the literature, we do understand that changing birth practices towards a more natural event in a woman's life, is one that has begun at different settings around the world. The aim of many studies presented here is to characterize hospital care for childbirth with regard to humanized birth

and to identify obstacles as well as facilitating factors to implement humanized care, based on women's perception. Institutional factors, hospital protocols, and health professionals' individual practices, represent barriers that separately or jointly hinder the implementation of a humanized model for childbirth care in the hospitals . There is still no concrete knowledge about the perception of humanized birth care amongst the individuals of a highly specialized university affiliated hospital. Moreover, we have yet no evidence as to the facilitating factors or the barriers present in the adoption of a more humanized method of childbirth care in highly specialized and university affiliated hospitals in Canada. Understanding the potential barriers and facilitators in the implementation of a more humanized approach to birth in the context of obstetrically high-risk pregnancy cases and labour, is thus crucial.

The first article of the thesis develops a conceptual framework using the concept of organizational culture to examine childbirth practices as cultural and social practices. In this article, we propose a conceptual framework based on Allaire and Firsirotu's organizational culture theory (1984), as a means of examining birth care patterns as an organizational cultural phenomenon. We also explain why this framework is appropriate for studying childbirth practices. We attempt to operationalize the conceptual model by using a previously published study that examined the cesarean section rates in Lebanon.

ARTICLE 1:

UNDERSTANDING CHILDBIRTH PRACTICE AS AN ORGANIZATIONAL CULTURE PHENOMENON: A CONCEPTUAL FRAMEWORK

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Abstract

During the past few decades, giving birth has developed into a highly medicalized procedure in North America, as well as in other developed countries. Explanations for increases in medical interventions, such as caesarean section and epidural analgesia are linked to social and cultural trends which encourage patterns of obstetrician-centered authority, and passivity in women's role during birth. Medicalized birth prevention similar to humanistic intervention practices, focuses predominantly on women-centered care. However, these approaches had limited success, especially in the highly specialized care hospitals. In order to understand the main values and beliefs that might promote humanized birth practices in the specialized hospitals, we primarily need to be able to articulate a theoretical knowledge of the social and cultural characteristics of the childbirth field and the relations between these and the institutions.

The purpose of this paper is to provide a conceptual framework, which describes the potential barriers and facilitators, present in the humanization of birth practice in the highly specialized hospitals through the scope of an organizational culture model. The literature review allowed us to extrapolate how social and cultural factors contribute to birth practices, and how these factors likely overlap, and mutually reinforce one another, instead of complying with the organizational culture of the birth place. We propose a conceptual framework to examine childbirth patterns as an organizational cultural phenomenon. Allaire and Firsirotu's organizational culture theory served as a guide in the development of the framework. We discuss the application of this model in understanding the influences of organizational culture components in the humanization of birth practices in the highly specialized hospitals. and elaborate on how these components configure both the birth practice and women's choice in highly specialized hospitals. This

framework might help to direct attention to organizational and cultural properties when considering childbirth intervention aimed at changing the medicalization of birth practices in hospitals in the future.

Introduction

According to the recent Canadian Perinatal Survey, 97% of all births took place in hospitals, 1.2% and 0.8% took place in a private home or in a birthing centre respectively (SPSS, 2008), and out of these, 3 out of 4 women undergo some form of medical procedure, such as caesarean sections, labour induction, epidural analgesia, amniotomy, amniocentesis, and others (CIHI, 2007). The total C-section rate in Canada in 2005–2006 was 26.3%, and this rate was 81.9% among women who had a previous C-section, (CIHI, 2007). The increase in C-section rates has been associated with changes in maternal characteristics, such as higher maternal age, lower parity, and high pre-pregnancy weight. However, changes in obstetric practice due to changes in maternal characteristics and the concern of fetal and maternal safety has also greatly influenced the increase in primary cesarean delivery (Green & Baston, 2003; Liu & Sia, 2004). Noticeably, women's choice in accepting obstetric intervention, also is considered as a factor in the increase of C-section rates (Green & Baston, 2007). Although women may not be requesting cesarean sections or other obstetric interventions by themselves, they seem to be keener on accepting such obstetrician's suggestion in their case (Green & Baston, 2003). The use of other medical interventions, such as epidural analgesia, Electronic Fetal Monitoring (EFM), and induction of labour has dramatically increased in the recent years in Canada. Epidural analgesia was used by 57.3% of women, about 90.8% followed by electronic foetal monitoring, and 44% of women had the experience of induction of labour. (Chalmers, et al., 2008; CPSS, 2008)

The increase in the medicalization of birth, as well as routine obstetric interventions, has been shown to be harmful to women and babies during labour and do not appear to guarantee safety during birth (Anim-Somuah, et al., 2005; Annibale, 1995; Biasucci, et al., 2008; Donna, 2002; Hall & Bewley, 1999; Keefe, 2002; Leeman, et al., 2003; McCool & Simeone, 2002). Despite using a high level of medical interventions, the United States has the highest maternal and infant mortality rates among the developed countries (Keefe, 2002).

The technological and biomedical advances in obstetrics played a key role in providing the obstetricians with more authority over women's experience of pregnancy in the United States (Davis-Floyd, 1992; Rothman, 1989).

The humanization of childbirth is considered as an alternative model to the medical and technological models of birth (Misago, et al., 2001; Page, 2000; Umenai & Wagner, 2001). Most of the previous literature has defined the humanization of birth as a birth without any unnecessary medical intervention, and as a women-centered care approach in which women are respected regarding their values, beliefs, autonomy, choices, and their control over their bodies and births (Jones, 2002; Page, 2000; Umenai & Wagner, 2001). However, humanized care is a changing and developing process and when it comes to high-risk pregnancies; it aims at enhancing patient care for the improvement of the birthing experience in hospitals. The finding of our previous study dealt with the necessity of having humanized care in the presence of medical interventions by providing continued support to the women, and by developing the caregiver-women relationship, as well as helping the estblishment of a mutual decision making process (Behruzi, et al., 2010b).

In a highly specialized hospital, many of the patients are considered as high-risk, so they would need specific attention and care. Some of the high-risk antepartum patients and their families have to adapt with long hospital stay and confinement to bed rest. On the other hand, labelling women as high obstetric risk produces stress and anxiety which can influence the outcome of pregnancy, therefore, the most important role of health care providers is to focus on normality and caring approaches in the middle of an abnormal situation (Lindsay, 2006).

Previous research has shown that the hospital's policies and procedures, inadequate staffing, technology-focused care, and a lack of continuity of care were considered barriers towards a more humanized birth approach in the specialized hospitals (Campbell & Rudisill, 2006). Lack of continuity of care is an important barrier towards humanized birth care in almost all the hospital setting in Canada. A survey by Public Health Agency of Canada's Canadian Perinatal Surveillance System (CPSS) showed that 50.6% of women reported that they did not have the same caregiver both prenatally and at birth. 42.3% of these women said this would have been important for them to have the same care provider (CPSS, 2008).

In order to understand the principal values and beliefs promoting humanized birth practices in the specialized hospitals, in the first position, we need to be able to articulate a theoretical knowledge of the organizational and cultural characteristics of the childbirth field, and the relations between these and the institutions. There is a certain lack of knowledge on how collective organizational culture components could influence women's experience of birth, as well as birth practices. We may agree with many feminist scholars, who argue about male power and their control over birth. However, we must emphasize that we cannot fully understand the gender influences on birth from the feminist literature, until we analyze how the gender experiences are first

influenced by the organizational culture of the institution where the birth takes place.

However, even when focusing on the social and cultural aspects of birth (either separately or both), most of the existing studies still do not manage to focus on the embedded social and cultural norms of an institution or their consequences on birth practices. Moreover, a theoretical framework drawn to study these issues from an organizational/cultural point of view has not yet been developed (Callister, 1996; Callister, 1995; Callister, Semenic, & Foster, 1999; Dillaway & Brubaker, 2006; Jordan & Davis-Floyd, 1993; Khalaf & Callister, 1997; Leeman, et al., 2003). The purpose of this paper is to provide a conceptual frameworkthat would allow the identification of the barriers and facilitators regarding the humanization of birth practice in specialized hospitals through the scope of an organizational culture point of view.

This paper represents a unique attempt in that we will be the first to discuss the social and cultural aspects of childbirth as embedded in the organizational culture of an institution. We will also discuss the feminist framework of childbirth, since this is considered the most important scholarly model of birth that advocates a humanized birth approach; we will further discuss the limits of feminist literature regarding the analysis of medicalized birth practices. We will furthermore characterize childbirth as an embedded organizational culture event, and propose to study childbirth from an organizational culture perspective. Using Allaire & Firsirotu's (1984) theory of organizational culture, we will finally propose our conceptual framework and examine the organizational culture components pertaining to it, as well as their relationship to the birth practices through the aid of previous literature.

Birth as a Social and Cultural Phenomenon

Childbirth has both a biological and a cultural definition. It is also a political and social phenomenon (Schneider, 2002). Esposito (1999) argued that the social and cultural power is what creates the potential for diversity in birth, beliefs, practices, and experiences. Liamputtong stated, "the social meaning of birth is shaped by the society in which the birthing women live". Feminist researchers have also argued that our cultural attitudes towards birth differ according to the individuals' social culture, social class, and social resources (Lazarus, 1994; Liamputtong, 2005; Martin, 1992). For example, middle class women seek more medical technology as a way to control their births (Liamputtong, 2005). According to Davis-Floyd (1992) human being's actions, such as the cultural creation of traditions, customs, and rules construct childbirth practices directly and these actions take place through social interactions, communication, and exchanges inside the social institutions (Davis-Floyd, 1992).

Considering pregnancy as a socially constructed event, Schneider (2002) assumed that "women's views reflect, more or less, the views of the health professionals, family, friends, and those in the literature" (Schneider, 2002). The socio-cultural view of birth may lead to enhancements in services for both the mother and child, and help professionals to be more attentive to cultural differences in the beliefs and behaviors of women (Artschwager Kay, 1983). Anderson (2004) also argued that the way women view their care, and their willingness to receive such care during labour and delivery has greatly changed from the 1980's notion of having a 'natural birth', to an increased request for ' medical technology' in the 21st Century (Anderson, 2004).

The social features of birth including cultural ideas and social support systems have an important impact on birth practices. Social scientists have

argued that a medicalized birth is determined by embedded cultural ideas in which progress and technological birth practices are defined as a victory of civilized society over the ancient feminine nature of birth. Consequently, women are controlled through more and more medical practices in order to prevent any risk for themselves and their babies (Mansfield, 2008). This view of birth helps us understand how birth is perceived and practiced as a socially embedded experience, whilst maintaining an emphasis on the role of the hospitals in providing safety.

Social scholars have argued that social dimensions of birth are inherent in natural childbirth whilst at modern-day, escape from society back into nature seems impossible due to the fact that in real situations, both the women and the care providers integrate elements of modern medicine into a previously natural childbirth (Macdonald, 2006; Martin, et al., 2003). Macdonald (2006) stated that the concept of a "natural birth" should be redefined according to the professionals, specifically the midwives, politicians, and of course, women. Macdonald (2006) concluded that the experience of a natural birth in contemporary midwifery in Canada reflects and promotes an understanding of this concept in modern Canadian society. She also makes room for the role of biomedical technology and hospital spaces, but supports this through the midwifery logic of caring and choice (Macdonald, 2006).

The limitation of the existing socio-cultural studies of birth practices is that they fail to explore the organizational culture dimensions of the institution and their role and power over the changes in birth practices towards a more humanized one. What kind of socio-cultural opportunities or constrains are imposed on organizations trying to adapt humanized or medicalized birth approaches?

In the following part, we discuss the feminist theory of childbirth as being one of the best frameworks to understanding our proposed conceptual

framework. Following this discussion, we will highlight our reasons for choosing the organizational culture theory for our conceptual framework.

The Feminist Framework of Childbirth

Feminist activists have provided a new insight into childbirth, and opened the doors to new topics for research, including the sociology of childbirth (Rothman, 1982). During the 19th and early twentieth centuries the first wave of feminist activists argued persistently for women's rights to relieve their own suffering, and hence to gain control over the birthing process, the right to be given extended choices during childbirth, and to have full control over their body, as well as their reproductive life (Leavitt, 1984; Reissman, 1983). The consequences of the struggle of the first wave of feminist activists on childbirth were beneficial, as women gained the right to use pain relief drugs and to being heard on their preference for or against it; however, women lost control over the process of childbirth, as well as allowing birth to continue to shift from home to the hospital (Leavitt, 1984).

In the late 1960s and early 1970s, the second wave of feminist activists began to take an active interest in the 'alternative birth' or 'natural birth' movement, and once more advocated home birthing as well as midwifery services (Beckett, 2005; Klima, 2001). The feminist activists became much more aware of how the widespread use of technology caused women problems with their body image, and their powerlessness over birth. In this second movement, feminists advocated a more humanistic, woman-centred, and holistic approach to pregnancy and childbirth (Crouch & Manderson, 1993; Lazarus, 1994; Schneider, 2002)

Most of the feminist scholars described 'natural' or 'normal' births as part of a social process which was based on different cultural ideas (Mansfield, 2008), however, they ignored the analysis of natural birth from the

organizational and cultural viewpoint. In the United States, the 'home birth' movement represented an extraordinary collaborative effort between feminists and traditionalist women, both of whom desired a more natural approach to giving birth. Nevertheless, now remains the question of who are the actors who play the key roles in this matter, and what strategies are present to facilitate a more humanized birth care approach in specialized hospitals?

From feminist literature, it can be understood that certain facets leading to the medicalization of birth have developed on a *gender* perspective basis (Macdonald, 2006). Some have, for example, made critiques over men's control over childbirth, and the establishment of modern medicine and obstetric technology being the cause of women's normal birth processes considered as pathological events (Martin, 1992; Martin, et al., 2003; Reissman, 1983; Rothman, 1989). Some of the feminist literature focused on the effects of the medicalization of birth on the nature of the women's childbirth experiences, on their loss of control over their own births, and on not truly having a choice in the hospital birth setting (Martin, 1992).

Nevertheless, Dillaway et al (2006) criticize the feminist study of birth, and state that previous conceptual approaches that focus solely on gender oppression, fail to fully explain the birthing experience from diverse dimensional standpoints (Dillaway & Brubaker, 2006). While the feminist critiques of medicalized birth care have contributed greatly to our understanding of the patriarchal construction of childbirth as a gendered process, these approaches still rarely consider how these gender issues might interact with the 'organizational culture' of the birth place, to affect women's experience. (Dillaway & Brubaker, 2006; Jordan & Davis-Floyd, 1993; Leeman, et al., 2003; Litt & NetLibrary Inc., 2000; Rothman, 1989)

Moreover, birth practices have been analyzed through a cross-cultural perspective by many anthropologist and feminist scholars (Callister, 1996;

Davis-Floyd, 1998; Jordan & Davis-Floyd, 1993). The feminist/cultural perspective had contributed to our knowledge of the varieties of birth practices among different cultures (Jordan & Davis-Floyd, 1993). However, in recent years, feminist literature has started to uncover women's own views on medicalized birth, and to show women's desire for the medical model of birth, such as the epidural analgesia, in the hospital setting (Davis-Floyd, 1992, 1994; Dillaway & Brubaker, 2006; Fox & Worts, 1999; Martin, et al., 2003). Davis-Floyd's study showed that 70 percent of the interviewed women were both excited and comfortable with their highly technocratic childbirth experience (Davis-Floyd, 1994). Lazarus showed in her study that women participants, to some degree, accepted the medical view of birth, and that women's concerns about safety made them feel better in the hospital environment (Lazarus, 1994). It seems that the medicalized birth system is more embedded in American culture, as American women are less likely to question the use of particular procedures in hospitals (Dillaway & Brubaker, 2006).

From the feminist cross-cultural studies, we realize how differences between birthplace, race, ethnicity, and the religion of women play a role in their decision-making on medicalized birth (Davis-Floyd, 1994; Fraser, 1998; Jordan & Davis-Floyd, 1993; Rothman, 1982). Previous research has shown that most Japanese women prefer to have a natural birth, and avoid epidural analgesia and other medical intervention at birth (Behruzi, et al., 2010a; Taniguchi & Baruffi, 2007; Yeo, Fetters, & Maeda, 2000). In contrast, one half of Canadian women chose a method of pain relief, such as epidural analgesia and 81% rated it as 'very helpful' (CPSS, 2008). Davis-Floyd (1994) argued that technology is seen as essential to all aspects of American life, and women fully expect a technocratic birth in order to ensure that their births are well managed, controlled, and safe. Interestingly, choosing to give birth with the assistance of technology provided women with a sense of control, according to the Davis-Floyd's study (1994). We also understand that African-

American women had more desire for medicalized births because of their historical lack of access to appropriate medical care, and mistreatment by professionals (Fraser, 1998). Jewish women, even more than African American women, embraced the medicalized approach (Litt & NetLibrary Inc., 2000), and Canadian Orthodox Jewish women are seen as less active participants of the childbirth care decision, as well as relying more heavily on the physician as the care provider (Callister, 1996).

Finally, the contemporary feminists or 'third wave of feminist activists' argue about women's choice and their positive experience of obstetric technology at birth. This group of feminist emphasize that technology is not essentially a male-gendered product for the establishment and continuation of obstetrician's authority at birth, and it can serve women's needs and purposes. Beckett (2005) argues that women can purposefully choose and benefit from the utilization of obstetric technology (Beckett, 2005).

However, to our knowledge, no research has been done so far on how the organizational culture of the hospital setting may change women's decisions when choosing a specific medical intervention, such as an epidural, or a caesarean section. Understanding women's perceptions of and decisions about medical intervention is only possible if we pay attention to the commonalities, and differences, among the organizational culture in the environment where the birth takes place.

Choosing the 'Organizational Culture' Model Theory for Childbirth Practice

Reviewing the literature formerly mentioned in this paper, indicates that authors have been able to extrapolate how social and cultural factors contribute to birth practices, and how these factors likely overlap, and mutually reinforces one another instead of supposedly embedding within the

organizational culture of the birthplace (Davis-Floyd, 1994; Kabakian-Khasholian, et al., 2007; Newburn, 2003; Rothman, 1982). Liamputtong (2005) has argued that individual's choices, and sense of control are determined by their social positions (Liamputtong, 2005). Lazarus (1994) emphasized that knowledge about childbirth encompasses both biological processes of birth, as well as social knowledge about the way the health care system works. According to Lazarus (1994), institutional knowledge refers to its bureaucracy, the people who are responsible for making decisions, and the ways that a woman can exert pressure in order to obtain the kind of care she wants (Lazarus, 1994).

In order to improve childbirth practice, we need to understand the way birth is experienced by women and also the "internally consistent and mutually dependent practices and beliefs that exist around it"(Jordan & Davis-Floyd, 1993). Newburn's (2003) findings demonstrated that women's needs are not being adequately met in many birth units in hospitals, and that there is a lack of knowledge among women (particularly those expecting their first baby) about what they should expect from the specific hospital that they chose to be their birth setting (Newburn, 2003). The literature shows that the social atmosphere greatly influences the health care professionals' practice and the women's experience of birth (Beckett, 2005; Behruzi, et al., 2010a; Bergeron, 2007; Dillaway & Brubaker, 2006; Green & Baston, 2007). For the majority of women, it is important to have access to epidural analgesia, and to a special care unit for the baby (Newburn, 2003). However, individual factors, such as convenience incentives, the social ambient, and their role in increasing the intervention at childbirth, have never been addressed through a comprehensive organizational culture model.

Moreover, humanizing childbirth draws away a phenomenon of organizational change. It is obvious that to understand whether hospitals are able to transform themselves, it is not enough to study only their definite

rational characteristics. Organizations also include a culture that is formed by values, beliefs, and signification, all of which constitute the very foundation of organizational functioning (Allaire & Firsirotu, 1984). The study of organizational culture allows us to understand the values and assumptions towards medicalized vs. humanized birth practices, in specialized hospitals. Dastmalchian (2000) stated that organizational culture is a unique area in which a conceptual work and research can serve as a guidance for practitioners (Dastmalchian, 2000). Moreover, Esposito (1999) argued that "the process of birth provides a structure around which the social and cultural forces can guide its expressions"(Esposito, 1999).

In the present paper, the conceptual model of "organizational culture" introduced by Allaire & Firsirotu (1984) is considered a comprehensive and appropriate theoretical model for the study of childbirth practice in specialized hospitals, specifically if we are aiming to explore the barriers and facilitators on the path to making birth practices more humanized in such hospitals. This model allows researchers to explore the cultural precipitations of childbirth through the lens of an organizational/ cultural study, in order to understand which childbirth practices work best for which cultures.

Consequently, we will describe the organizational culture theory. After conceptualizing childbirth as an organizational culture phenomenon, we will then introduce the properties of Allaire and Firsirotu's (1984) organizational culture theory model.

Definition of Organizational Culture

Understanding organizational culture is important because culture gives meaning, clarity, and direction to the action of an organization and its members (Coakley & Scoble, 2003). Organizational culture represents a collective set of expectations, definitions, and memories that characterize how

things are happening in an organization. Cameron (1999) and Schein (1984) have defined 'organizational culture' as a pattern of basic assumptions that a group of people has invented, discovered, or developed in learning to cope with problems, such as its external adaptation and internal integration (Cameron, 1999; Schein, 1984) .

Every organization has a culture and culture has a powerful influence on an organization as a whole, as it directly affects all the decisions that are made. The most important elements of organizational culture seem to be: *the environment, values, heroes, rites and rituals, and the cultural network* (Deal & Kennedy, 1982). According to Morgan (Morgan, 1998), these elements as well as philosophies which run in the organization, and the influences that culture imposes on the behaviour observed in the workplace should be understood. Deal and Kennedy (Deal & Kennedy, 1982) add that a strong culture is a system of informal rules that dictate how people are to behave most of the time, and as such they enable people to feel better about what they do, encouraging them to work harder. Moreover, it seems that the culture's influence over people's perceptions, thoughts, and feelings is related to the duration of time they live in this culture and to its oldness (Schein, 1984). Understanding the nature of organizational culture is possible by simply observing the groups/organisations' functioning (Morgan, 1998). According to Allaire and Firsitrotu (1984), organizations are basically social constructions *emerging* from actors making sense of ongoing streams of actions and interactions (Allaire & Firsirotu, 1984).

Research into organizational culture has often been qualitative, but the inherent richness of the organizational concept has led researchers to use different methods of research in order to study organization. Some researchers have used the organizational culture model as a global concept, and have studied organizational practices across different cultures and continents (Dastmalchian, 2000; Halabi, 2005; House, 1999; O'Reilly & Chatman, 1991).

Description of Allaire and Firsirotu's 'Theoretical Model of Organizational Culture'

Firsirotu (1984) first proposed a completely conceptual model of organizational culture which represents organization as three inter-related endogenous variables, these being: *social structure, culture,* and *individuals,* all of which are influenced by the external factors surrounding organization, which in turn include: *society, history,* and *contingency* (Fig 1). The links that exist between these elements show the present and future situations into which organization has plunged itself. This model would prove useful in understanding institutional dynamics (Allaire & Firsirotu, 1984), as well as allowing researchers to determine the appropriate strategies necessary in order to improve childbirth practice towards a more humanized, and less medical approach.

Next, we will cite authors which have contributed to the description of the internal and external components of the organizational culture model theory as explained by Allaire and Firsirotu (Allaire & Firsirotu, 1984). We will use these to better understand the meaning of this theory.

External factors

Society: The environment in which an organization is constructed, and how this functions, has a large influence on the organization. Society also defines the judicial and socio-economic context to which an organization must adjust.

History: The history of an organization includes the way, and reasons, why it has been created. These include the founder's vision, the values of past leaders, the successes and the failures, which the organization has seen, reasons for past leaderships, and finally the routine and rituals that have been exerted over the years. History shapes attendants, past histories of integration, the beliefs' roots, and the expression of the organizational culture, as well as its structural architecture.

Contingency: Contingency consists of the technology, economics, competition, and the regulations that characterize an organization. The way of functioning and the survival of the organizations deeply adaptive to the type of cultural appearance it portrays, and the structural struggles that organization might be going through.

Internal factors:

Socio-structural factors: This consists of the strategies, structures, policies, and management processes in the organization. It includes all aspects of the organization's functioning, such as: formal goals, objectives and strategies, authority, power structure, control mechanisms, rewards and motivation, and the managerial processes and style.

Cultural factors: Cultural factors manifest themselves strongly in *myths, ideologies, and values*. This phenomenon is observed in rites and rituals, customs, metaphors, glossaries, lexicons, acronyms, slogans, stories, legends, symbolic artifacts, design, and architecture. The history, the environment, and the contingency of an organization shape culture.

Individual factors: These consist of people in different hierarchical levels of leadership roles, as well as passive recipients, who simply contribute to the meaning of the organization. Knowledge, cultural competence, values, assumptions and expectations, and needs and motives, are the factors, which

affect the relationships between actors, and the extent to which meaning is shared with other actors in the organization.

In the following part, the authors will now describe the basis of the conceptual framework of Allaire and Firsirotu's (1984) model of organizational culture.

Insert Figure 1, about here

The Conceptual Framework for Understanding Childbirth Practice

As we mentioned previously, the aim of this paper is to develop a conceptual framework that can be used to describe and evaluate the organizational culture's dimensions which could act as barriers, or as facilitating factors, in the humanization of birth practices in specialized hospitals. Our suggested conceptual framework (adopted from both Allaire & Firsirotu (1984) and Halabi (2005) is presented in figure (2).

Insert Figure 2, about here

According to this framework, a spherical shape reflects the permanence of the relation between the different components pertaining to each of the organization's levels. The main concept under study "the humanization of birth" as a potential characteristic of the birth context figures in the heart of this organization, modeled by it and influencing it in return. This interaction, as well as that laying between the Allaire and Firsirutu's two levels of an organization, is expressed by discontinued lines separating the different spheres of the framework. This represents the permeability between the spheres, which in turn shows that the roles of the different components at the

different levels of an organization can be seen as possible facilitators, or barriers to the implementation of humanized birth in a specialized hospital.

The conceptualization of humanized birth by the feminist literature refers to a women-centered care, a choice, control, and continuity of care (Davis-Floyd, 1994; Lazarus, 1994; Page, 2000; Rothman, 1989). The external sphere represents the exogenous factors of the organization, according to Allaire and Firsirotu (1984): the environment, the history of the organization, and its contingencies. The middle sphere in turn represents the endogenous factors of the organization, these being: its structure, its individuals, and its culture.

In order to demonstrate the operationalization concerning our approach, and attempt to reframe these findings using the concepts of our framework, we will argue some findings taken from an interesting and informative published study by Kabakian's (2007). In this study, semi-structured interviews were conducted with 20 key players including hospital directors, midwives, insurance bodies, syndicates and scientific societies, ministries. The authors analyzed the environmental factors which encourage cesarean section practices in hospital settings in Lebanon. Their findings reveal barriers and facilitators present in the achievement of more natural births, and show a reduction in the high cesarean section rates in Lebanon (Kabakian-Khasholian, et al., 2007).

Applying the Theoretical Framework in Order to Study Caesarean Section Practices in Lebanon

The organization of the health care system, as well as hospital policies, are significant factors affecting childbirth practices in Lebanon (Kabakian-Khasholian, et al., 2007). Kabakian-Khasholian's qualitative study (2007) shares our view of cesarean section practices as being an event, which is embedded into the social, economic, and care policy advances of Lebanon.

This study factors influencing the cesarean section practice. They can be classified intofour categories: (1) physician-specific; (2) women-specific; (3) financial; and (4) management of the organization of the obstetric care (Kabakian-Khasholian, et al., 2007). Using concepts from our framework, we can now reframe these influences in order to show an example of how the cultural and organizational dimensions of an organization can be understood regarding cesarean section practices in Lebanon.

In Kabakian-Khasholian's study (2007), the participating private and public hospitals had to adhere to contingency factors which acts as facilitators or barriers for the caesarean section practices. Nevertheless, the authors' definition of the concept of contingency encompasses Allaire & Firsirutu's definition as *technology, economic factors, rules and regulations, as well as the practice guidelines*. Analysis of the findings of this study showed that many contingency factors, such as unregulated health care system, dominance of the private health care sector, and private insurance, have created the optimal environment for the medicalization of birth in Lebanon (Kabakian-Khasholian, et al., 2007). Because of the lack of control over the quality of care, and the minimal role given to *regulatory bodies (contingency)* by the health care system in Lebanon, there is no accountability when it comes to physicians. These are no obligatory *practice guidelines (contingency)* for their practice and use of technology. The lack of power, by higher authority in private health care sector organizations in Lebanon, was considered as the main obstacle in the development and implementation of these guidelines *(contingency).* Women interviewed in this study showed a great interest in having a painless delivery. Epidural analgesia was considered as an agreeable method of pain relief among the women. Private insurance companies and public social security systems, however, did not reimburse women for epidurals administered during vaginal deliveries *(contingency)*; and in consequence, women's request for cesarean sections for a painless delivery has been increased in Lebanon.

Kabakian-Khasholian (2007) has argued that fifteen years of civil war in Lebanon has led the health care system 'which is basically categorized as private sector' to reach an almost insignificant level of control over the quality of care *(history)*. A minimal role has been given to regulatory bodies by the past and present health care system leaders in Lebanon (*history),* in order to advocate normal childbirth, and control over the high levels of medical and not evidence-based deliveries (Kabakian-Khasholian, et al., 2007; Khayat, 2000).

The Lebanese women's choices as well as their requests for epidural analgesia and caesarean sections revealed the *expectations, culture, values, and beliefs* of these women *(ambient society)* on birth, as well as their view of birth as a painless and medicalized event (Kabakian-Khasholian, et al., 2007). Authors have argued that this factor has played a key role in the increase of caesarean sections, and interventional childbirth practices. Furthermore, the interviewed Lebanese physicians had more inclinations toward caesarean sections than normal deliveries *(ambient society),* since they found them more convenient to schedule. Interestingly, some obstetricians also believed that repairing a caesarean section cut is easier for them than the cutting and suturing involved in vaginal deliveries. The Lebanese Society for Obstetricians and Gynecologists and the Ministry of Public Health have been interested in developing a national guideline for standardizing childbirth practices for a long time now *(ambient society & history).* However, this goal has not been achieved yet.

The hospitals*' strategies* towards childbirth practices, and the organization's special *goals,* plays a crucial role in the reduction of caesarean sections in some Lebanese hospitals (Kabakian-Khasholian, et al., 2007). In Lebanon, the health care sector is principally private and most hospitals did not have written policies for childbirth practices. In the Khasholian's study, a number of strategies (s*ocio-structural)* were identified, which could have

direct influences on the reduction in observed cesarean section rates in this country. Among them, instituting an 'audit system' in all maternity wards was a prominent one. This audit system was considered useful as it increased the individual's accountability (s*ocio-structural).* However, the *power structure* of private facilities towards preventing the implementation of this system, was considered a barrier (s*ocio-structural)*. Another strategy which has been suggested is the: *'change in type of practice'* strategy, in order to eliminate the effects of convenience factors. Unfortunately, the professionals struggled in trying to form a more collaborative environment, including: *team work trust, sharing and transforming care, and spiritual care,* (s*ocio-structural).* This strategy was unsuccessful due to the resistance of the Lebanese Society for Obstetricians and Gynecologists, and the lack of close collaboration between private and public organizations (s*ocio-structural)*. The *rewards*, *motivations,* and *compensation systems* in hospitals (s*ocio-structural)* may act either as facilitators, or in some cases, as barriers, in caesarean section practices. All the strategies that change the physician's reimbursement for cesarean sections and vaginal births, and reduce differences between these, or even eliminate them, were considered as facilitating factor in the reduction of caesarean sections in Lebanon (Kabakian-Khasholian, et al., 2007).

All the *symbols, ideologies, and values* which flow through the Lebanese hospitals and their individuals, might act as either facilitators, or barriers in the cesarean section practice *(culture).* In Kabakian-Khasholian's study (2007), the lack of need for a continuous medical education, and the absence of a culture, which accepts the need for evidence-based practices was considered as a barrier towards humanized childbirth practices *(culture).* The Lebanese Society for Obstetricians and Gynecologists presents a variety of obstetricians with a variety of educational and training backgrounds, and thus many different views towards childbirth *(culture).* The French and American educational systems are acceptable in Lebanon, and graduate students can follow up their study in the medical schools of Lebanon. Moreover, many

medical graduates returning back to Lebanon after graduating from Eastern European schools and other Arab countries, simply have to undergo an examination in order to receive their practice permit (Kabakian-Khasholian, et al., 2007). Once the license is received, there are no legal requirements for renewal of these permits (Kabakian-Khasholian, et al., 2007). Many of the unnecessary and harmful practices of childbirth, such as enemas, perineal shaving, episiotomies, and inductions of labour, are still routinely carried out in Lebanese maternity settings (Khayat, 2000).

Understanding the embodied organizational culture through the *attitudes of the individuals, their opinions, and their actions,* could lead to birth practices that are well adapted to certain populations *(individuals)*. The interviewed individuals in Kabakian-Khasholian's study (2007) were grouped into: 1) the administrative level of governmental and non-governmental organizations; these include: hospitals, insurance agencies, and college of physicians; 2) the professional level which includes obstetricians, anesthetists, pediatricians, nurses, midwives; and finally, (3) the women who gave birth at the hospitals *(individuals).* Most of the women participants in the Kabakian-Khasholian's study made a decision to receive caesarean sections, though, they did not have neither enough information about the side-effects of caesarean sections, nor of its post-partum period *(individual)*. The women interviewed *believed* that having a caesarean is easier than a normal birth *(individual)*. These women were not actively involved in the maternal health issues concerning their community. In contrast, women *valued* more highly being involved in social activities *(individual)*. Between all the individual factors which played a role in increasing caesarean section rates in Lebanon, a lack of obstetric *skills and knowledge* among young obstetricians which allow them to conduct operative vaginal deliveries, is seen as quite significant (Kabakian-Khasholian, et al., 2007).

We end to emphasize that the prenatal care approaches, however, could progress by being built from theoretically-based approaches, like the one that we propose here. Such approach explicitly identifies the relationship between organizational culture and childbirth choice practices. Efforts would thus go a step further to examine our proposed theoretical framework in the childbirth practices in a highly specialized university affiliated hospital. The organizational culture of the highly specialized hospitals and its impact on childbirth practices, either as barriers or as facilitators, reinforce patterns of childbirth that are observable and dominant in those hospitals. Efforts would then attempt to take action that would configure conditions that need to be created to enable humanization of birth approaches in such kind of hospitals.

Implications for Further Studies

Any attempt to decrease the biomedical model of birth, and to replace it with a more humanized approach in specialized hospitals, needs to be preceded by a thorough understanding of the role of the different actors which are responsible for the continuation of such practices. This conceptual model helps us to gain an insight into the different opportunities which are available for this change, as seen in the North American hospital setting. The hospital culture, and its social context, as well as hospital policies, are significant factors involved in the increase in the technocratic model of birth, in most modernized and developed countries. The role of contingency factors, such as rules and regulations, technology, and economic status that impact the specialized hospitals, either by promoting, or discouraging humanized or medicalized birth approaches, has not been explored yet in North America, specifically in Canada. The developed conceptual framework can be used as a tool for future studies of birth, with the aim being to gain an insight into the organizational culture components which act as barriers or facilitators in providing humanized birth practices and reducing medical intervention.

Conclusion

This paper contributes in developing a framework that helps understand the organizational aspects of childbirth. This conceptual framework can be used in the analysis of birth practices in hospitals in order to explore the external and internal organizational factors, which play a role as facilitator or obstacle on the humanization of birth practices. We have adapted this framework to the findings of a previous study in order to provide insights into how organizational culture dimensions impact the style of birth practices. Thus, any effort towards providing more humanized birth care in highly specialized hospitals needs to be first highlighted by a thorough understanding of the different organizational culture properties, which are indeed responsible for the implementation and continuation of this practice. The conceptual framework proposed in this paper can be used as a tool for understanding the barriers and facilitating factors encountered in the humanization of birth practices in the hospitals, where a high level of technological and medicalized birth practices exists. The level of specialty and technology in the highly specialized hospitals might have more influence on the humanized childbirth practices, which entails the necessity of further investigation in those hospitals. Nevertheless, the conceptual framework is also applicable for examining humanized birth practices in other hospitals regardless of the level of specialty.

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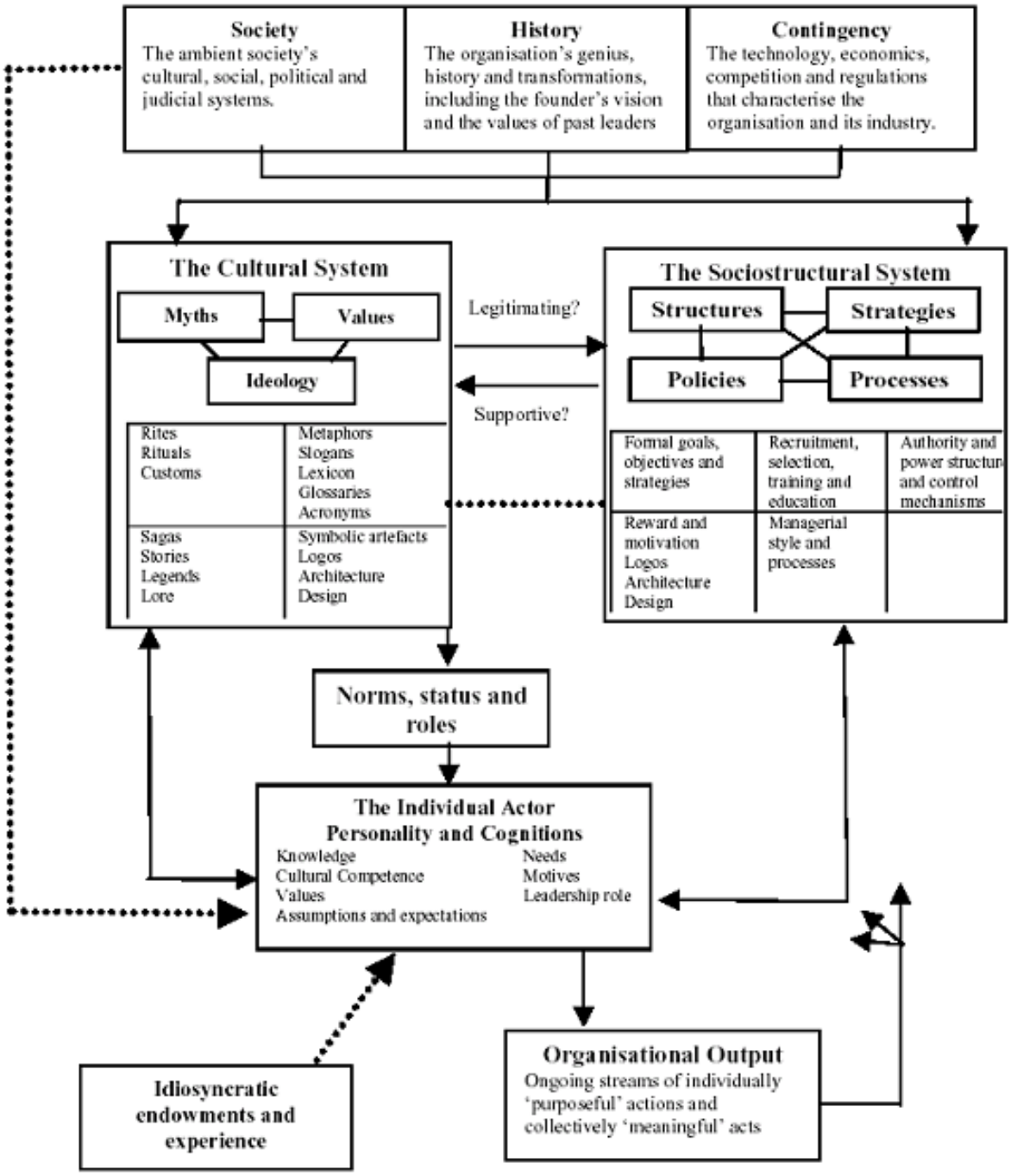

Fig 1 : Conceptual Framework of Organizational Culture

(Allaire and Firsirotu 1984)

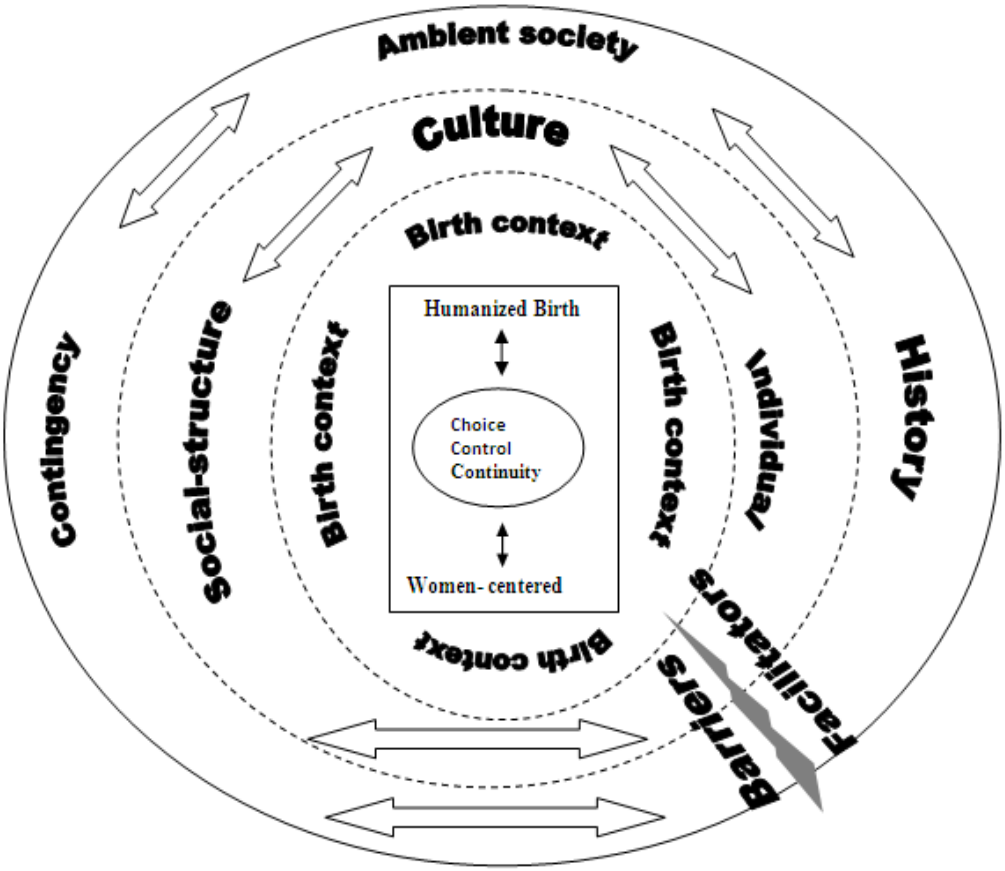

Figure 2 : Representation of Organizational Culture Conceptual Framework for Childbirth Practices (adapted from Allaire and Firsirotu Organizational Culture Theory, 1984 and Halabi 2005)

RESEARCH QUESTIONS

The review of literature of the present study has raised the following questions to which we aim to respond through the two oncoming articles:

The Main Research Question is:

Regarding the internal and external components of an institution, what are the factors that facilitate, and what are the barriers that prevent a fourth level specialized and university affiliated hospital in Quebec from adopting a humanized child birthing care?

The first specific research question that is answered through the second article of the thesis in accordance with the administrators of the institution, the multidisciplinary professionals, and the women:

1) What is the definition of humanized care?

The study sought to answer three more specific questions through the third article:

2) What are the components of the history, the contingencies and the ambient society that act as facilitating factors, or barriers, preventing this level 4 specialized and university affiliated hospital in Quebec from adopting humanization of birth care ?

3) What are the components of the socio-structure, the individuals and the culture that act as facilitating factors, or the obstacles, preventing this level 4 specialized and university affiliated hospital in Quebec from adapting humanization of birth care?

4) What are the potential interactions between the components of these two levels of the level 4 specialized and university affiliated hospital in Quebec specialized in mother and child's health care on adopting the specific humanized child birthing care?

We will present the methodology of this study later in this section.

CHAPTER III: METHODOLOGY

The present chapter will present the design, the setting where the study took place, the sample, the data collection followed by data analyses and ethical issues.

1. RESEARCH DESIGN

A case study was considered to be the most adequate design for this study, as it allowed the holistic and meaningful characteristics of real-life events to remain untouched, such as organizational processes (R K. Yin, 2003), whilst contributing to develop our knowledge of the organizational phenomenon (Gilgun, 1994). This was an embedded case study (R K. Yin, 2003) since particular attention was paid to people in the organization which were classified under three levels as 'administrators', 'professional', and 'patients'.

2. THE CASE UNDER STUDY

The case under study in this research was *Sainte-Justine Hospital*, in Montreal, Quebec, Canada, which is part of the Mother and Children's Network of Quebec. The reason for choosing this unique case was the fact that the investigator intended to explore the humanization of birth practices in a university-affiliated hospital, since this is one of the centres for mother and child care in Quebec where a high level of technology as well as specialists are present. Sainte-Justine Hospital has 450 beds, including 30 beds at the Intensive Care Unit, and receives 19,000 in-patients yearly. Every year, about 3900 births take place in Sainte-Justine Hospital, and about 40 % of all pregnancies are complicated.

Whilst many of the women which had been referred to this institution were labelled as being high-risk, and thus needing specialized attention and intervention; there were other women who were cared for, at the same hospital but did not suffer from complications described as being at high obstetric-risk. The investigator was thus interested in exploring the birth practices in such hospitals, and identifying the potential facilitators and barriers towards the humanization of birth care. The choice of setting was also influenced by the on-site accessibility of the investigator.

3. POPULATION AND SAMPLES

The sampling for this study targeted people from different administrative and professional levels of the hospital, as well as women who had recently given birth in the maternity wards. A non-probabilistic, purposeful sampling method was used in the qualitative parts of the study where individuals were chosen for their specific key characteristics (Fraser, Maunsell, Hodnett, & Moutquin, 1997). The investigator also purposefully chose a sample of women with a broad diversity in pregnancy and delivery types, such as high-risk pregnancies, normal pregnancies, nulliparous or multiparous pregnancies, and those who have had normal vaginal, instrumental, or caesarean deliveries.

The sample size for the interviews was not fixed at first, since the interviews took place until saturation's occurrence. The respondents were also invited to suggest other people for the investigators to interview (R K. Yin, 2003). The full sample included: 1) *the administrative level*; 2) *the professional level comprising of a multidisciplinary team*; and *3) the women*.

The inclusion criteria for administrators and professionals were their ability to speak, read, and write in French or English. The women who were deemed eligible to participate in this study had to fit the following criteria:

they had to be 18 or older than 18 years of age irrespective of their level of risk or parity, they had to be able to speak, read and write in French or English. This was a pre-requisite to fill out a self administered questionnaire. They had to be within 24 to 48 hours postpartum, they had to have given birth in the hospital; and finally, they had to give their consent in order to participate. Exclusion criteria included women with intrauterine death and this was due to the fact that such a condition may influence the birth experience.

The sample size estimation for the quantitative part of the research was based on the previous study conducted by De Koninck (2001), and following these parameters: a standard deviation of 0.6, and a distance from mean to limit of 0.1 and a 2-sided alpha level of .05.[1] Therefore 139 patients were required, assuming a 25% probability of drop out, we aimed to recruit 180 women. As a whole, ten women refused to participate in the research, twenty-five women did not fill out the questionnaire, and the researcher due to incomplete answers withdrew three questionnaires. A total of 157 complete questionnaires were thus analyzed in the study. The response rate was 85%.

The women in this study were asked if they desired to participate in the study, and were asked if they could be observed by the investigator during their delivery. They were also interviewed, and asked to fill out a questionnaire. The period of collecting data lasted for 6 months. The different methods of data collection used are presented below:

4. INSTRUMENTS AND DATA COLLECTION

The “deeper” levels of the organizational culture of an institution are seen as being beliefs and assumptions, and they are often best understood from

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[1] $N = \frac{(1.96)^2 \times (0.6)^2}{(0.1)^2} = 139$

a qualitative point of view (Schein, 1984). It has been suggested that organizational studies often use various methods to capture the multiple dimensions which make up the components of an organization (R K Yin, 1994). The present study was thus conducted by a case study approach, and by using a simultaneous methodological triangulation design as well as collecting quantitative data in order to complement a qualitative approach.

Multiple sources of data were thus used in this study including: *documents, archival records, semi-structured in-depth interviews, direct observations, and a self-administered questionnaire*. These various sources of evidence are complementary to (and characteristic of) a good case study; since they can help us to deal with the problems encountered in establishing the validity and reliability of case study evidence (R K. Yin, 2003). The researcher was able to perform a triangulation of the data sources, which deepened the understanding of the organization (R K Yin, 1994), as well as reduced the chance of bias (Hardon, Boonmongkon, & Streefland, 1994).

4.1. Interviews

Semi-structured interviews were conducted with six administrative representatives of the institution, and with eleven maternity care professionals in the hospital as well as with ten women who had been hospitalized there during the postpartum period. The interviewees were invited to express their views on the characteristics of care in their institution and the humanization of care, as well. Several other questions posed also allowed the investigators to explore the perceptions and experiences of the interviewees regarding the organisational barriers and/or facilitators concerning the humanization of the birth practice. The questionnaire *(Annex 1)* which was answered by the interviewees consisted of several themes; these being: 1) the ambient society with regards to birth care practices in a specialized hospital; 2) the history of the hospital; 3) the contingencies within the hospital; 4) the hospital structure; 5) the individuals; and 6) the culture. All of these themes can represent barriers

or facilitators in the humanization of birth practice. All the interviews conducted with the administrators and professionals took place in the hospital - in an office of the research centre.

The interviews conducted with the women, on the other hand, took place in the postnatal unit or in their rooms. The researcher entered into the maternity wards and sampled the available mothers. Interviews with the women took place within 24-48 hours postpartum for a normal and instrumental delivery and within 24-72 hours after a caesarean section. The interviews did not last any longer than 45 minutes for all cases. *(Annex II)* The timing of the interviews respected the availability of the interviewees. All the interviews were audiotaped and transcribed later. The ethical aspects of this were considered by asking for permission to use an audiotape recorder, as well as note taking during the interview.

4.2. The Questionnaire

Questionnaires were used in the present study in order to explore the women's experiences of childbirth care in the highly specialized hospitals with emphasizes on the humanization and continuity of care (De Koninck, et al., 2001). The questionnaire was used before to assess the midwifery practice in Quebec compared to the standard, especially with regard to humanization and continuity of care. The reliability of the questionnaire was assessed by Cronbach's Alphas; its values ranged from 0.71 to 0.93. The questionnaire was adapted for the needs of the present study and were printed in both official languages. *(Annex III)* The questionnaire was first pretested with a sample of 20 women in postpartum. Based on comments received, the modifications were made. The final questionnaire comprised of four parts and 94 multiple choice and open-ended questions. The questions encompassed the women's previous maternity experience, as well as health-related consultation habits (9 questions), their pregnancy (33 questions), their delivery and after-delivery

experiences (43 questions), and finally, some additional personal, and socio-demographic questions (9 questions). The open-ended questions allowed women to elaborate theirs satisfaction and comments about the care they received during perinatal period.

4.3. Documents

The use of the content analysis of documents allows the researchers to corroborate data, and to increase proof and evidence for their claims by consulting other resources (R K. Yin, 2003). Documents of different natures, which bind history, contingency, and the socio-structural, and cultural aspects of the hospital, such as administrative documents, proposals, progress reports, internal records and newspaper clipping were used for this study whilst respecting the administrators' approval *(Annex IV)*. The information was gathered through the systemic search for any relevant documents during data collecting plans, such as field visits, and using the local library while examining the available files (R K. Yin, 2003).

4.4. Archival Records

Archival records have been known to be used in conjunction with other sources of information to produce a case study (R K. Yin, 2003). In the present study, the hospital charts of the participating women were consulted in order to triangulate the obstetrical data, and the whole process of care surrounding childbirth. Socio-demographic data, history of previous and present pregnancy and childbirth outcome were gathered from the participant's hospital records.

4.5. Direct Observation

According to Yin (R K. Yin, 2003), observational evidence often proves useful in providing additional information about the topic being

studied, and according to Deal and Kennedy (Deal & Kennedy, 1982), what people do is determined by what they value. A comparison between what people say and what they do, is thus a good measure of their cultural cohesion (Deal & Kennedy, 1982). In the present study, direct observation was divided into two parts: 1) observation of both normal and high-risk deliveries; and 2) less formal direct observation through field visits. This part of the study consisted of observing the general birth practice, the interaction between women and their health care providers, and the care provided by the attending birth care givers with regards to humanized birth. This activity was conducted in the maternity unit. The investigator was present at the maternity wards five days a week during the data-collecting period. She asked the women who were admitted to the hospital if they accept to participate in the study, and if they allow her to be present at all stages of their delivery from the time of admission, to the end of third stage of labour, as an observer. All the women who accepted the presence of the researcher during their delivery signed an informed consent form. These women were also asked to participate in an interview, and to complete a questionnaire -in order to triangulate the sources of data.

4.6. Observation of deliveries

The investigator observed the birth practices and deliveries of six normal and four high-risk women in the mentioned highly specialized, and university affiliated hospital. This was done in order to explore the potential barriers and facilitators present in such a hospital regarding humanized birth practices. As this research did not aim to verify a hypothesis or theory, the observations simply explored the real birth practices by using a grid developed for the same objective by (Vadeboncoeur, 2004) . (*Annex V)* The field notes of observation were organized into different categories, such as expectation for delivery, companion, information, decision, and control.

4.7. Observation by field visits

All that was seen or heard, all the activities carried out in the maternity wards, particularly during the deliveries, and the general circumstances around the birthplace were all noted and subsequently analyzed according to the research questions. Field notes of events and conversations, such as interactions between women and their attendants, and unstructured conversations between the researcher and the women were recorded. Even conversations between the researcher and the birth care providers were noted because these conversations were spontaneous, and might thus reveal some facts which would be impossible to discover only through semi-structured interviews. In addition to the specific field-notes recorded in the maternity wards, some general visits around the hospital as a holistic organization were also carried out during the period when the researcher consulted the patient's hospital records. Observations were also noted regarding the activities and interactions of the actors which played a part in different areas of the hospital in order to determine the potential barriers and facilitators present in the humanization of the birth practice specifically.

5. VALIDITY AND RELIABILITY OF THE STUDY

For the quantitative aspects of this study, the reliability of the questionnaire which was used here has been assessed by Cronbach's alphas. The values for this study range from 0.71 to 0.93 (De Koninck, et al., 2001). For the qualitative part of study, the criteria explained by Seale (Seale, 1999) and Lincoln (Lincoln & Guba, 1985) have been used. These criteria namely include credibility, conformability, transferability, and dependability. The several activities which were carried out -such as obtaining coefficient reliabilities, data triangulation, referential adequacy, persistent observation, and prolonged engagement member check- increased the probability of the credibility of the findings (Maputle, 2004; Stake, 1995). Through this multiple

approach to data collection, extraneous influences are also likely to be eliminated, or nullified (Stake, 1995). Some of the participants were given the opportunity to check the adequacy of the transcripts of their interviews. The investigator also spent a lot of time on the interviews, and was persistent in her field observation until data saturation was perceived.

The conformability of this study was achieved through the involvement of an experienced supervisor and co-supervisors, whom collaborated during the different levels of the development of the study, and acted as examiners of: codes, transcriptions, written field notes, documents and findings, raw data, tape recorded data, etc. *Transferability* of the study was attained by a clear description of the research methodology, and finally, *dependability* was achieved through the examination of documents, interview notes, and the findings, as well as interpretations of the codes and records by the same investigator with a minimum interval of six weeks to confirm that these findings supported the data.

6. DATA ANALYSIS

6.1. Qualitative Data Analysis

All the taped recordings in the present study were transcribed. The transcriptions were carried out by a French speaking assistant. All the data which stemmed from interviews, unstructured conversations, field-notes, observation sheets, and documents (as well as archival review notes), as well as the comments and the explanations from the answers to the open questions, were analyzed through *inductive (in the second article) and then deductive (in the third article) qualitative content analysis* methods. The computer programs 'Word 2007' and '*QDA Miner' (version 3.2.3)* were used in the step involving the qualitative analysis processing of the data. Analysis of the documents,

however, was limited to the search for themes, which answered the questions raised in this research.

The data coding for the second and third articles was performed by the use of a mixed coding model, as this permitted us to convert verbatim data into units of significance (Stake, 1995). The provisional codes (or the mega codes) necessary for a mixed-coding analysis of the data were in concordance with those mentioned in Allaire and Firsirotu's paper (Allaire & Firsirotu, 1984). For this step, I prepared the sub-codes according to certain components of the organizational culture model, including society, history, contingency, structure, culture, and individuals. The details of this analysis have been presented in the mentioned articles.

6.2. Quantitative Data Analysis

A *descriptive* analysis was carried out on the quantitative data collected in the present study. This descriptive analysis was performed in order to describe the socio-demographic status of the individuals who participated in the study, as well as for descriptions of several indicators, including: the quality of the prenatal visit setting, the quality of information received during the prenatal visit, the quality of prenatal care, the quality of the relationship with the prenatal care provider, confidence regarding delivery, quality of the setting for delivery, feelings of control over delivery, the quality of care during delivery, and more.

The *SPSS software (version 17),* and *descriptive statistics* (which comprises of the means and standard deviations calculated for continuous variables and the proportions of the obtained categorical variables) were two of the methods used in this study to summarize the responses collected in the questionnaires completed by the women.

7. ETHICAL CONSIDERATION

Ethical approval for the present study was requested from the Research Ethical Committee of Sainte-Justine's Hospital. Permission to access the childbirth units and to use hospital documents and charts was also obtained following the approval of the Sainte-Justine Hospital Research Ethic Committee. All the participants in this study were informed about the nature of the research project *(Annex VI),* and consent was obtained before any interviews could take place *(Annex VII, VIII, IV).* All the participant information collected was also treated as strictly confidential, and a study number was assigned to the participants on all the forms and questionnaires instead of their specific names, or any other identifying information being used. Before starting the study, the main investigator introduced her to the participants and explained the purpose of the study to them following ethical consideration. The signed consent forms and all other documents were also kept in isolated cabinets which were only accessible to investigator. Data which has been collected for the purposes of this research is due to be destroyed as soon as the articles presenting the findings of the study are published.

CHAPTER IV: RESULTS

The second and third articles comprise of the body of the thesis, as well as the findings of the study.

The second article of the study is entitled: “The humanization of birth in a highly specialized hospital. What are the perceptions of professionals, administrators, and women in this setting?” In this article we aim to answer the first question of this research.

The third article of this study is entitled: “The facilitating factors and barriers encountered in the adaption of a humanized birth care approach in a highly specialized university affiliated hospital”. This section describes the external as well as internal organizational culture components, which could act as barriers or facilitators in the humanization of birth practices in highly specialized hospitals. The third paper consequently addresses the main research question of this study, as well as other specifically related questions.

ARTICLE 2

HUMANIZATION OF BIRTH IN A HIGHLY SPECIALIZED HOSPITAL:

WHAT IS THE PERCEPTION OF PROFESSIONALS, ADMINISTRATORS, AND WOMEN?

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Abstract

Background: The excessive use of obstetrical intervention and operative births, in the absence of evidence-based indications, leads to the iatrogenic effects and the dehumanization of care for both women and babies. The humanization of childbirth is considered a complementary or alternative model to the medical and technocratic model of care. While the literature is abundant regarding the humanization of birth in low risk pregnancies, humanization in the context of a highly specialized hospitals where most pregnancies are at high obstetric risk is less often addressed.

Objective: The purpose of this manuscript is to identify the perceptions of professionals, administrators and women concerning the humanization of childbirth care in a highly specialized hospital in order to identify barriers to the implementation of such care in the specialized hospital.

Methods: A single-case study design and a qualitative descriptive approach were used. The case examined is a highly specialized university-affiliated hospital in Montreal, Quebec. The study population included 11 professionals, 6 administrators and 10 women who had given birth in the hospital during the study period. Methods of data collection were: semi-structured interviews, participant observation, field notes, and questionnaire. An inductive qualitative content analysis was performed.

Results: Analysis of the data uncovered the following themes as component of humanized care : personalized care, recognition of women's rights, the provision of humanized and family-centered care, women's advocacy and companionship, a compromise of safety, comfort and humanity, and non-stereotyped pregnancies in term of humanized birth. The pressure of saving life was considered as the most prevalent barrier for providing such a care in high-risk pregnancies.

Conclusion: The perceptions of humanized birth in a highly specialized hospital cannot be limited to the key concepts discussed in the preliminary conceptual framework of this study, namely, the concepts of choice, control, continuity of care, and women-centered care. It cannot be understood without integrating the concepts of safety and reassurance. Considering that the humanization of birth favors the emergence of a more sensitive and caring approach towards pregnant women, the importance of the professional attitude and behavior towards implementing such care in highly specialized hospitals is obvious.

Introduction

Technology and scientific development have provided undeniable advances in the quality of obstetric care. The evolution of modern obstetrical practice, including the ready availability of caesarean section, has resulted in a reduction in maternal and perinatal mortality and serious morbidity (Castro & Clapis, 2005). However, the excessive use of medical interventions and operative births without evidence-based indications has resulted in iatrogenic morbidity and contributed to dehumanization of care. Advances in obstetric technology may also have reduced direct care-provider patient interaction by through, the substitution with equipment, such as electronic fetal monitors (Biasucci, et al., 2008; Donna, 2002; Hausman, 2005).

The goal of maternity care facilities is to provide the highest quality care for both mothers and babies. In the context of a highly specialized hospital, significant proportions of pregnancies are at increased risk and require special attention. The literature shows that high-risk patients have unique physiological and psychosocial needs (Campbell & Rudisill, 2006; Maloni & Kutil, 2000). Previous research has also shown that women on bed-rest experience an increase in stress, loneliness, boredom, and a feeling of powerlessness (Maloni & Kutil, 2000), and that hospitalization often leads to a loss of autonomy and control, as well as an increase in women's sense of dependency on medical interventions. A lack of privacy, together with feelings of guilt, helplessness, depression, and anxiety, have been shown to contribute to psychological problems in women who are at obstetric risk (Campbell & Rudisill, 2006; Richter, et al., 2007).

Providing care for a high-risk pregnancy woman can present both challenges, and opportunities, for care providers accustomed to caring for these women (Campbell & Rudisill, 2006; Leon & Knapp, 2008; Soeffner & Hart, 1998). During hospitalization, care providers are presented with an

opportunity to provide supportive care and information to women in order to help them cope with the complications of high-risk pregnancy (Soeffner & Hart, 1998). Nevertheless, while care providers are often aware of the psychosocial problems faced by women with high-risk pregnancy and their difficulties coping, sensitivity to the severity of these problems is often lacking (Maloni, 1998).

In highly specialized hospitals, the physical environment is normally equipped with monitoring machines, etc. Due to this, one may expect that care might be generally more medicalized, and less humanized, in both low and high-risk pregnancy cases. In such contexts, clients may be treated as objects of technical intervention and the individualized psychological dimensions including fears, anxieties, and desires are may be given less importance. Since the benefits for technology may appear obvious, they may be used regardless of the clients' opinion (Mota 2006). Previous research has shown that the barriers to providing effective psychosocial adjustment for high-risk pregnancy women in intensive care units were the following: hospital policies and procedures, technology-focused care, inadequate staffing, and a lack of continuity of care (Campbell & Rudisill, 2006).

The humanization of childbirth is considered a complementary or alternative model to the medical and technocratic model of care. The literature is quite diverse on the concept of humanized birth, however, most literature (Deslandes, 2005; Kuo, 2005; Page, 2000; Umenai & Wagner, 2001) describes it as respect towards a woman's values, culture, beliefs, dignity, as well as desire for control over her childbirth in order to allow for her contribution regarding the decisions of what happens to her and her baby. The humanization of birth takes into consideration the spiritual and psychological, as well as the biological dimensions of a human being (Price, et al., 2007; Umenai & Wagner, 2001). It is defined as a health policy that seeks to improve care for women, as well as being considered as an alternative model

for medical or technical births, which encourages as natural a birth as possible (Castro & Clapis, 2005).

Although there is a worldwide movement to strengthen the arguments for the humanization of birth, we are still lacking a precise and concrete definition of the concept. This study, an organizational culture model introduced by Allaire and Firsirotu (1984) is considered as the theoretical framework. According to Allaire and Firsirotu's theory of organizational culture, it is necessary to understand the interaction in the institution between the external factors like "history, society, contingence", and the internal factors, such as "structure, culture and individuals" regarding the key concepts of the study. Thus, individual definitions and perceptions of humanized birth have to be understood first through the institutional structures that shape the individual experience. In this paper, we are interested in looking at "individuals" as sub-unit levels, including administrators, professionals and particularly women, and to describe subcultural values and assumptions pertaining to the humanization of birth in a highly specialized hospital.

In the previous literature (Almeida & Tanaka, 2009; Pope & Graham, 2001; Umenai & Wagner, 2001), the key elements of humanized birth care were considered to be: choice, continuity, control, and women-centered care. Humanized care in high-risk pregnancy is managed by continued support to patients, development of caregiver-patient relationship, as well as aiding woman to control their pregnancies through decision making process (Behruzi, et al., 2010b).

We have used these key elements in the core of our conceptual research framework aimed to develop it in the light of the findings of this study (Behruzi et al, 2010). Presented with the fact that each professional, each team, and each institution has, on the concept of humanization of care, its unique definition, and even philosophy, it was necessary to gain a thorough

understanding of humanized birth care in individual settings first, in this case, a highly specialized hospital. Once the perception of the concept of humanized childbirth has been acknowledged, the institutes can thus eventually change their practices accordingly in order to enhance the quality of maternity care.

The purpose of this paper is to identify the perceptions of professionals, administrators, and women, on the humanization of childbirth care in a highly specialized hospital in order to identify the factors that might have hindered the implementation of such care in these hospitals. The research question of this paper was: What is the definition of humanized care according to the managers of the institution, the various health care professionals and women?

Method

Study design, setting, and participating sample

A case study design focusing on a single case and a qualitative approach were used in this study in order to collect a comprehensive, flexible, and rich in-depth narrative data set (Miles & Huberman, 1994). Predetermined and relevant samples were chosen in order to ensure the diversity of the sample.

The case study for this research was conducted at a highly specialized hospital in Montreal, Quebec. This is a university-affiliated hospital which houses a unique centre for mother and child care in Quebec. The one with a high level of technological intervention and specialist personnel. This hospital receives referrals from outside of the Montreal area, and while approximately half of the women attending this hospital have high-risk pregnancies, the other half are high-risk pregnancies.

The sample in this study consisted of 1) professionals: six nurses, three obstetricians, one pediatrician, and one anesthetist; 2) six administrators from

different hierarchical levels of the hospital including: executive management of client programs, quality and risk management, management of clinical services, management of nursing care; and 3) 10 women who had given birth in the hospital. The professional and administrative participants were intentionally chosen from different disciplines with varied levels of work experience (ex. professional work experience in the prenatal, antenatal, postnatal, and neonatal care units at the hospital) and duration of serving in different units.

Concerning the women participants, ten women were purposefully recruited to the interviews to obtain a broad diversity in pregnancy and delivery types. To be included, the women had to: have given birth within 24 to 72 hours prior to the interview; be hospitalized in a postpartum unit of hospital; be primipara or multipara, have single or twin pregnancies, cesarean sections, or vaginal births, with or without medical intervention, be able to speak, read, and write in French or English.

Data collection

Ethical approval was obtained from the Health Research Ethics Boards of a Hospital affiliated with the Université de Montréal. Informed consent was also obtained from all the voluntary participants. As this study was part of a major case study, all the women participants in the interviews were asked to voluntarily sign a consent letter in which they allowed the investigator to be present as a participating observer during their labour, delivery, and the first few hours of postpartum. This made it possible for the investigator to fill out an observation sheet and record the field notes. The women participants were informed that withdrawal from the study was possible at any time, that they had the right to refuse to answer any question asked, and that participation in the study would not in any way impact on the care they received. For confidentiality purposes, the investigator also used a code instead of the

participants' names on the transcripts, and asked the participants not to mention any names during the interviews.

Most of the data was collected through in-depth, open-ended, semi-structured interviews with the participants. The interviews were forty to ninety minutes in duration. The additional data for this study was collected by means of field notes, participant observations. Women were asked to fill out self-administered questionnaires. There were 94 questions to cover the dimensions of humanized birth care as defined in the literature means choice, control, and continuity of care, as well as socio-demographic questions. The data from the questionnaires were presented in another article; however, the socio-demographic and obstetrical data were used in this paper. The data-collection period spanned November 2007 to March 2008, and it continued until a sufficiently rich description of the concepts under study was achieved (Hardon, et al., 1994).

Interviews with the professionals and administrators were performed in their respective offices in the hospital. All interviews with the women participants were conducted in their postpartum hospital room at a time that was convenient for both the women and their families. For two participants, the husband was present during the interview, and they were generally very supportive and keen to provide complementary comments to the women's responses. The interviews were conducted by the main investigator, a PhD candidate with a background in midwifery. All interviews were conducted in French and later translated into English for publication.

All the interviews were audio-taped with the participants' consent. The investigator used two separate interview guides based on the conceptual framework and literature review (Creswell, 2007). The main questions the professionals and administrators were asked during their interview were the following: Could you please explain your definition of humanized care? Do you have any specific philosophy in this hospital regarding humanized

childbirth and care? What are your opinions on the subject of humanized care in high-risk pregnancy cases, as well as low risk pregnancy cases in this hospital? What do you consider to be a barrier or facilitator for humanized birth care regarding high and low risk pregnancies in this hospital? The main questions that the women participants were asked were the following: Could you tell me about your personal experience during pregnancy and delivery? Do you have any specific values or preferences regarding the childbirth practice of this hospital?

These guides were initially used during separate interviews with two professional nurses and two women in birthing centres, and were pre-tested and validated before being used in this study, meanwhile, the interviews were recorded and transcribed, then transferred into a qualitative software namely QDA Miner (*version 3.2.3)* , and the data was analyzed. After reflection on preliminary data collection from those four interviews, and identifying strengths and weaknesses of of questions, the initial interview guides were revised by investigators for further probing of the data (Creswell, 2007).

Data Analysis

As a whole, 27 interviews were audio-taped and transcribed, then entered into a qualitative software package (the Atlas ti 5). The field notes, field observations, the archival and administrative documents were also entered into the same software. Inductive content analysis was performed in this study. In inductive analysis, the themes are strongly linked to the data themselves (Patton, 2002). The main author proceeded from understanding the generalized meaning of the participants' answers, and marked them by codes that provided a pattern of simple meanings and reordered these simplified codes into new themes and sub themes, which highlighted the essential description and perception of the interviewees regarding humanized birth.

The content analysis first was performed for a random sample of seven interviews. After an eight-week interval, the same sample of interviews were entered into a second qualitative software package (QDA Miner) in order to compare the feasibility, and the fitness of each software package with our method of analysis, whilst at the same time allowing a code- recoding to be carried out by the same investigator in order to achieve an intracoder reliability coefficient. In the end, the main investigator used QDA Miner for the present study as this software proved to be more suitable for the purposes of our analysis. In order to obtain a reliability coefficient, the authors used the simple following formula:

$$\frac{\text{\# of Interviews coded the same by A in the 1st and 2nd coding}}{\text{\# of Interviews coded by A in the 1st coding}}$$

The intracoder reliability coefficient was shown to be '0.80' or higher for all the samples. The principal investigator had the opportunity to do a member check and to measure the participants' validity for two sample interviews with professionals; however, she used the triangulation method in order to cement the trustworthiness, and validation of the data. To ensure that the data analysis in this study was thoroughly systematic and valid, all the recorded tapes, interview transcripts, and matrices were examined several times. The investigators also discussed the accuracy of the data as well as the coding logic, in order to be sure that the code system was in fact accurately measuring that which the investigators wanted measured. Using a constant comparison method, the data was further categorized based on whether the contents 'felt alike' or 'looked alike'. The investigator examined and re-examined the codes for withdrawing themes, which may reveal actual analytical messages of the regularities and relationships between the codes. The category system was redefined systematically in order to reflect the purpose of the content analysis.

Results

The participant professionals' mean age was 44 years, and they (range - 23 to 56 years). Four had a Bachelor's degree, one a college diploma, and one a Master's in nursing. Of the other five, three had an MD, and two had an MD and a PhD. The mean age of the administrators was 49, with a range from 38 to 60. Of these, four had a Masters in Science, one a Bachelor's degree, and one a DES in Health care administration. Two of the administrators had a background in nursing. The mean age of the women interviewed was 31, and they ranged from 22 to 40. Four out of the ten women had high-risk pregnancies. One of the ten interviewed women had a third degree laceration, while nine had no complication at all during delivery. None of the interviewed women had postpartum complications. The socio-demographic characteristics of the women interviewed are shown in table 1.

Table 1 about here

By inductive content analysis of the data, seven themes were emerged, all defining the humanized birth care in a highly specialized hospital (Table 2 & Fig 1).

Table 2 about here

Personalized care

Care that is tailored for and responds to women's needs: The professional and administrator participants stated that humanized birth cannot be understood unless each woman is considered as an individual:

> **Prof 8:** I would say that having a human approach for me is really to consider the other person, and all the differences and peculiarities which are connected with this particular person…. a human being who has a spouse, family, children, ethnic origin, different priorities (obstetrician).

The obstetricians stated that the care provider's speech, approach, and care, should be adapted to each person. They perceived personalized care as 'a care that is tailored to the needs and expectations of the individual'. The professional and administrator participants concurred that care provision should be adapted to women's desires and should meet both their physical and spiritual needs:

> **Prof 1: […]** you really have to see all the dimensions, bio, psycho, social and cultural, you need to really see all of the criteria; it is not just the physical (aspects) we want to deal with (nurse).

> **Prof8:** When you have a little spare time, create a link with the patient… sitting down, taking time to listen, to ask if she has questions, repeat as needed, change your words to ensure that she understood, reassured, supported (obstetrician).

When it came to high-risk pregnancies, administrator participants expressed that care should be even more personalized regarding these individuals, and the specific needs of a person facing such difficulties:

> **ADM4:** I do not put all patients who experience a high-risk pregnancy in the same group at all. Every woman, every family is different. They have their (own) experience, they have their (own) history, diet, everything […] so it is us (that we should) adapt to all this and respond to the extent possible, to improve pregnancy outcome. But at the same time, not give the same thing to everyone and really adapt to the needs of families (administrator).

> **ADM3:** The capacity to meet the needs of patients, a goal they have set before they get pregnant[…] then, how to respond to the patients' image that they have made of childbirth (administrator).

The analysis of women's narratives showed that 9 of 10 interviewed women qualified the received care as a personalized or very personalized one.

Recognition of women's right

The right to choose and participate in the decision-making process: Administrators, professionals, and women with high and low risk pregnancies perceived the humanization of birth as reception of care that includes dignity and respect, and which also considers women's right to choose and participate in the decision-making process:

> **ADM1:** Defending women's rights, I will tell you: her right to control her body, her right to relieve pain, her right to give birth according to her wishes. I probably sound very feminist (administrator).

Both women at low and high-risk emphasized the benefits of making the decisions for themselves, as well as being heard, and responded with the following:

> **OB1:** It needs to respect the woman, if she does not want drugs or medication, it is perfect, and we respect the decision. If she wants them, perfect, she is respected as well. Her needs are really her needs, because she experiences all (woman at high-risk).

> **OB9:** Yes, it's me. It's all me. I decide if I will or I will not (woman at low risk).

Analysis of the women's narratives, as well as observation, field notes, showed that most of the women participants considered that they had no alternatives in their choice of a birthing place (10 of 10 interviewed women), 9 of 10 interviewed women were not able to choose among different birthing positions, but wherever it was possible, the women were still being respected in their choices. Moreover, 3 of 10 women interviewed did not participate in every decision being made. The findings also showed that it was the care providers who proposed most of the choices, and that sometimes, they were

quite directive. Some women felt that they were under too much pressure to start breastfeeding in the early moments after giving birth, and a low risk woman explained that: “they do not let us adapt to the new situation, they put pressure on me or the baby to have breastfeeding at small intervals”. The spouse of one of the low risk women mentioned that:

> ‘the physician did not spend enough time describing procedures or assuring my wife. Her role was really important. She put my wife in a position to choose an epidural too early”.

Finally, even though the epidural method of relieving pain was strongly suggested by care providers, not all women would choose it:

> **OB5:** I did not want to do it, so they left and they accepted my decision because I wanted to leave it normally, as it must be natural. I can give birth naturally with the pains that come with it. We have accepted the situation, and we must pass through it (woman at low risk).

Women’s right in high-risk pregnancy: Women at high-risk needed to share their choices and decisions with a familiar and trusted care provider. Lack of transparency in providing knowledge and woman at high-risk considered information, and being under pressure to accept medical intervention. One of these women said that:

> “they were hiding the truth from me and it made me so angry, I thought that if they told me everything, and allowed me to decide about my own situation, I would have been happier and more satisfied”.

Another high-risk woman said that she would like to participate in the decisions that must be taken, whilst keeping her privacy and boundaries respected by professionals in a perfect way:

> **OB8:** Humanized care! What it means to me, is that it's a care where there is respect for human rights [….] knowing that each of the parties (the health professional and the patient) has responsibility; so for me it's the respect of rights and responsibilities (woman at high-risk).
>
> **Prof 5:** That is all, to respect personal integrity in its individuality (nurse).

However, not all the participants agreed with full decision-making rights for the women where a high-risk pregnancy was involved:

> **ADM1:** sometimes there are decisions that must be taken right there and then, and I'm not sure women have all the tools to do so (administrator).

One of the administrators said that women at high-risk can make some of the decisions, but that they should be in compliance with their medical team and nurses:

> **ADM2:** when it comes to high-risk pregnancy, physicians tends to take control of the situation, and in my opinion, there is not enough room for choice, and humanized care. Even mothers feel they lose control or hand over control to the experts. So, it looks like the couple abandons the desire a little bit in a way in order to put things in the hands of the experts for the well-being of the infants (administrator).

Even more, one of the professionals restricted the decision-making right to women who do not have a high-risk pregnancy:

> **Prof 10:** I think what is important is that the staff has an open mind, an open mind in the sense that it is the woman who decides when there is no particular problem (low risk), she decides herself (anesthetist).

Humanely caring

To have a more human manner: Most of the participants at the studied hospital perceived humanized birth care as an optimum caring of women and their families. Some of the recorded sentiments on humane caring included: “a warm and intimate contact”; “attention”; “physical contact”, “an adaptive care towards the family as if they were our mother, or our father, or sister”; “caring for the individual and the family who are in front of us”; “taking care of someone when you hear her in her full definition”; “providing humanized care for someone”; and “when one forgets oneself and thinks of others”:

> **Prof1:** It is really the whole concept of caring theory; that it is not just medicalized care (nurse).

The women participants in this study experienced humanization of birth as a certain kind and gentle behavior shown by professionals who assist them during labour and delivery. Two women who were very satisfied with their care providers stated:

> **OB5:** When working in a hospital, you must have a big heart. Just because you're in a hospital you're not just going to work, you know that you work with human lives and therefore it must be done with heart. Here you see that everyone comes to your side, everyone wants to help as best they can (woman at low risk).

> **OB2:** […] Women need someone human, someone who has a heart, a certain gentleness, someone who knows how to behave. It's like a psychologist… he chooses words to relieve us, despite our pain. When there is someone in front of you who speaks to you gently and explains things to you, it makes you calm, it makes you smile, it gives you a sign that she really is there to help. That's the human side to me, especially in the field of childbirth (woman at low risk woman).

The nurse and obstetrician participants were concordant with the fact that humanized birth needs to be both professional and human. Nursing professionals stated that humanized care manifests itself in the nurses' attitude, behavior and even gestures and words. Obstetricians particularly experienced humanization of birth care as a dimension of care rather than a technical or robotic one:

> **Prof8:** Even if these women have childbirths or pregnancies that are more medicalized, I think we are capable of being human (obstetrician).

According to the professionals, everything depends on how the care providers act, and how they could adapt the medical dimension of care to one with a more humanistic approach for high-risk pregnancy cases:

> **Prof8:** When we have medicalized care in a high-risk pregnancy, we must monitor it. We must give medication to the patient and keep her in intensive care afterwards. I think all of these should be done very humanely (obstetrician).

> **Prof 10:** if the mother is very sick, she might be informed of the caesarean. That's the first thing we'll ask her once she is awake; we will show her the baby, we will try to involve the father as well, but there is certainly less humanization of care. I think we do with what we can do in those cases (anesthetist).

Good communication as a humanistic approach: Almost all the professional participants concurred that having good communication with the women and their families, and explaining the interventions that they are about to undergo to them, would largely facilitate humanized birth care, especially in high-risk pregnancies:

> **Prof 5:** Everything depends on how we act. We take the time to explain to the mother what phototherapy is (for example), what Bilirubin is,

> how she will be treated, how the baby will react, and why the baby (she or he) must be monitored. You can take the time to be human with the patient... (nurse).

> **Prof 10:** I like to explain what happens during an epidural, how they will feel when they go into labour, ... even if you have an epidural, it can still be very painful, you will have sensations, that's normal, I will reassure them when patients are not adequately relieved, I'll explain why, what happens inside them, why they have pain, what we can do for them…When there are caesarean sections, I will explain what happens and I will show the baby to the father at birth (anesthetist).

The humanization of birth is perceived as a way to deal with all the modern technology while being able to keep an interpersonal relationship and good communication:

> **Prof 10:** Occasionally we'll ask them for more surveillance, if they will allow more invasive monitoring. But we explain it to them; there has never been a patient who has refused. That's because patients know that we did it for them, and above all, that it's always for the baby. They are always told that if they're okay, their baby is also fine (anesthetist).

Obstetrician participants stated that good communication is a facilitating factor for the achievement of the humanization of birth:

> **Prof7:** In general I think that when we have good communication, good agreement with the patient, and mutual respect; we can achieve that objective -humanization of birth- (obstetrician).

> **Prof8:** Communication is necessary, whether for the announcement of bad news, or the management of patients with particular problems, so I think it must be a facilitator of the humanization of birth (obstetrician).

Both women with low and high-risk pregnancies emphasized the importance of receiving information and explanations during labour and

delivery as a factor of humanized care. Most of the women participants mentioned that they received explanation about the prescribed tests and the ongoing interventions and most of them qualified the information as complete and clear. They believed that medical procedures are better justified when information is communicated:

> **OB1:** I also believe that humanization involves allowing someone who may be unfamiliar with the human body (, such as the women) to understand what is going on and be able to make the right decisions by oneself based on what is happening. I chose a cesarean section because my concern was over the risk to the baby (women at high-risk).

> **OB2:** I was followed by a very good nurse who took the time to explain everything to me ... she explained to me what the medication was that she was going to inject into my blood, what was going to cause contractions, how it was going to happen ... she also explained the dosage to me […] (women at low risk woman).

One of the nurse professionals said that gentle explanation to women about the importance of each intervention and decision is a kind of humanized care:

> **Prof 1:** … Explaining the importance of signing off their discharge, for example: "you have the chance to go home, you can find your things" is done to show them the positive side of the situation, rather than simply saying "I must put you out because I need the bed for another patient" (nurse).

Family-centered care

Involvement of whole family in care: Almost all of the administrators, and most of the professionals, stated that the humanization of birth is a family-centered care where the integration, collaboration, and co-operation of the

concerned family is institutionalized by means of discussions with the parents, and their involvement in decisions and care of their baby:

> **Prof4:** The first step in the humanization of care is to involve the patient and his family in the care (nurse).

> **ADM5:** [...] to ensure the collaboration and participation of the family in the caring of the child (administrator).

> **ADM1:** It is clear that our care should be focused on what the family needs … the woman has a major role in the decisions regarding her birth. It is her body, and it is her baby. The husband also has a role in it since he is the father of the child (administrator).

One of the administrators mentioned the specific needs associated with the integration and major involvement of families in child care. He emphasized that a focus on families has proved a very helpful approach towards the achievement of humanized birth care not just in maternity care, but also in pediatric care:

> **ADM5:** [...] I think they want to understand what happens to their child, as well as observe, ask questions… when parents are involved with the care they receive, it diminishes all the stressors. At first, it was stressful for professionals, but ultimately, it is very beneficial (administration).

According to the professionals and administrators, it is necessary to adapt to the rhythm of the family and respect them in their journey. This is defined as working with the family's goals in mind and respecting their beliefs and philosophy in life:

> **Prof3:** This is not just about being a person who dictates what will be done with the woman, but it is also about working with them according to their beliefs and desires, as well as their routine. To me, that is humanization (nurse).

The family-centered care approach was considered even more important by the administrator and professional participants, when dealing with high-risk pregnancy cases. They explained the importance of adopting different protocols and guidance rules whilst dealing with each family:

> **Prof1:** (Referring to high-risk pregnancies) "We have protocols, and we try to respect them as much as possible, but I think it must always be respected in considering the family, the patient in the middle of health problems. [….] it (care) should be adjusted with different protocols, and I think that if we explain what is expected of the patient clearly, the patient will be more receptive, she will be back to the hospital, and it will not offend any of her beliefs and values. Furthermore, I think that if we do not confront the woman's basic beliefs and values, this is humanized care (nurse).

The expressions, such as: "being at the center of our concerns", "welcoming parents to be there", "being included in the care her own care and that of her baby", "being able to be with the baby throughout all the assessments", "being included in the decision-making"; and "having their concerns listened to" were mentioned by most of the participants, however, family-centered care was the issue the least raised by women participants. A woman who was at high-risk said that in humanized birth "it is not the caregiver, who is at the center, it is really the child, the baby, the mother, and finally the patient who are at the center".

For some women and professionals, sharing responsibility, and empowering the family, was perceived as form of humanized care:

> **OB1:** The family has access, and can move around. When … (name of the mother) needs cold water, it is I who brings it. So my involvement has become an experience for us in the way we plan to take the mother into account. She must continue bed rest (at home) […]. This allows the fathers to be educated quickly, to do all the things needed. I'll also

> be able to help …(mother's name) at home after. For me, this is much more humanized care (Husband of a woman at high-risk).

> **Prof10:** The humanization of care involves the woman who has given birth. She must have her baby with her, and she must be able to take care of (him/her) as soon as possible, and be close to (him/her), even if the baby is sick (anesthetist).

Women's advocacy and companionship

Comprehension and support: Personalized and family-centered care was the most prominent theme expressed by professionals and administrators, while the women participants' perception of humanized birth focused more on comprehension and emotional support. Women participants described their perception of humanized birth with words, such as "feeling understood", "feeling surrounded", "feeling empathy", "assistance or support", and "women's advocacy":

> **OB2:** Having a staff member or just someone on our side to support us, either morally or otherwise (women at low risk).

> **OB4:** I wanted someone who understood me and who supported me throughout the labour, and that's what I got from my nurse and doctor (women at high-risk).

The humanized birth was perceived when the care providers kept the women informed about the progress of their labour, as well as what was going to happen. From the point of view of one of the administrators, supporting women meant; "doing whatever we must for the family". Professionals also expressed the fact that women at high-risk pregnancy needed more sympathy and support:

> **Prof10 :** I think there is a sense of guilt for those who have experienced epidurals, or those who need a caesarean. Today, I think

> even women would like to give birth as naturally as possible. When things do not happen that way, they think it's their fault, they take it personally, and the people here (the care providers) need to ensure them that they should not feel like that, that this happens often (anesthetist).
>
> **Prof 6:** I think they (high-risk pregnancy women) need to verbalize their experience; they need to recover after they have been in labour for three days, followed by an emergency cesarean section… we do what we can with what we have, but as I said earlier, it is different for these women (nurse).

Companionship and continued support: Some of the nurse professional participants conceptualized humanized birth as: "being with the woman", "being present", "the ability to be with the family", and "being available, on demand". The lack of continued emotional and physical support caused one of the women to make the decision to have an epidural analgesic during the early stages of labour:

> **OB3:** I was in a lot of pain; I could not talk too much. My nurse was in another room assisting the birth of another woman. We had to call someone so I rang another nurse who came in and who understood that I was in a lot of pain**…** I was asked what the threshold of pain that I was feeling was, and if I could continue a little bit? I said eight out of ten. She asked if I thought I could continue, then immediately I said yes, but at the same time, I had reached my threshold of pain, and I said that I would favor having the epidural if I was feeling that much pain. So my nurse immediately called the anesthetist (women at low risk).

Women participants did appreciate it when the nurses were present more for accompaniment, rather than just being recalled for services each time. A woman at low risk explained her experience of the first phase of labour as following: 'I thought we were a little lonely me and my husband, because the nurse was not there all the time'. Almost all the observed labours by the

investigator were going the same way, and the women were told by the nurses that they could call for anything at any time, but they were not present continuously during labour. During active labour, however, the nurses were always nearby. Some of women participants in this study expressed feeling abandoned by nurse, and experienced stress when they had to wait until their nurses came to their room. The women at low risk stated that:

> **OB7:** I was with my husband; I felt the pressure, on the rectum and the vagina, a very intense pressure, it was painful, and at the same time a very quick pressure. There was no interval time between the 2 or 3 minutes (contractions). At this moment, I pressed the button to call the nurse. I checked the (uterus monitor) for tension… the physical monitoring showed it...baby's heart beat was going up too much. It exceeded 160, and I got worried, a little panicked. I called the nurse. She came quickly and she called the doctor quickly (woman at low risk).

> **OB5:** 'They were still there, but it's not the same as having someone by your side... I do not know how it happened for the others, but it was always like that. When I rang, however, she came. She still took time to come but she came anyway' (woman at low risk).

Another low risk woman stated that: "when she (the nurse) was there, she really paid attention to my requests, but she was not present in the room the whole time, and I realize that it would have helped if she had been there throughout the first stage of labour'. Moreover, she stated that the presence of a knowledgeable and experienced nurse gave her a higher sense of security, assurance, and support, than did her husband's presence:

> **OB3:** I think it would help anyone to have someone who is there just to discuss things during labour, in order to think of something else. My husband and I would not talk the same way because we know each other, unless it promotes relaxation. It would prove more relaxing,

> however, to talk to someone who has already experienced childbirth, and who is used to giving advice (woman at low risk).

A compromise of security, comfort, and humanity

A secure, confidential, and assuring environment: Providing a safe and secure environment for the women was described as humanized care by some of the professional and administrator participants:

> **Prof2:** Well, the humanization of care for me is to accompany the patient in a safe environment, giving her everything that I can, but in a safe environment (nurse).

> **ADM3:** It is doing all we can do to respond to women's needs while maintaining a safe care, safety for the mother, and safety for newborn, as well as dealing with all the modern technology in order to keep an interpersonal relationship, an element of trust between the professional and the patient, as well as her spouse and any family around her. For me, that's humanization of care (administrator).

One of the administrators said that the presence of technology and competent professionals are not only convenient factors, but in fact also humanized care, since they save lives, and thus bring reassurance to women:

> **ADM3:** […] is she feeling reassured? Does she have confidence in me? Does she feel good? All this is what makes it humanized care. Even if on the outside (in the hospital) everyone is thinking of it (the humanization of birth care), when we are providing health care, even if we have a lot of technology, the women still say that they feel safe, confident, and that they have their say (administrator).

The anesthetist participant expressed the fact that a humanistic approach regarding a high-risk pregnancy involves the presence of an expert,

or experienced care provider, around the mother during labour and delivery, in order to bring more assurance and security to the woman:

> **Prof 10:** I'll accompany her to make her see that she is not all alone […] in my opinion; she expected to have experienced staff around. More experienced staff means that they will be more able to say: "that's not a surprise, it happens, it takes longer, it is more important to have a healthy baby… to the women"(anesthetist).

> **Prof 2:** Mothers almost profit to be in a hospital. We try, even if it is a high-risk pregnancy, to meet their needs, always making them feel that they are in a safe environment (nurse).

For both the women participants at high and low-risk, being in a secure environment, such as a highly specialized hospital, and being assured by a competent professional, was perceived as the ultimate idea of birth care and humanized birth, because this way, the women did not feel any more anxious about the outcome of the pregnancy, or the baby's safety:

> **OB6:** as I feared having more risks in further pregnancies, they continued to follow me, and… how I could say that… I was reassured. if something went wrong, at least I was in a hospital that was specialized for children. I knew there would be no problem with the baby after that, everything was here; there was no need to transfer the child (woman at high-risk).

> **OB 8:** What was important for me was to be surrounded by experts, by competent professionals, and if anything ever happened to my baby, to be sure that I had a specialist with me (woman at high-risk).

> **OB10:** […] feeling safe in the operations that occur, because so many things can happen. It can move quickly, it can go well, it can go badly, and it can be complicated. At the same time, we know

> we're in the right place for all eventualities, that's how I felt (woman at low risk).

Two woman at high-risk stated that the use of technology and high monitoring was reassuring as it eliminated their uncertainty, and answered their questions about the baby's safety:

> **OB6:** But despite all the technology, I was reassured by the monitors, I heard the heartbeat, I felt no movement in my belly, but I heard the heartbeat, so I knew somehow that all was going well (woman at high-risk woman).

> **OB4:** […] we had ultrasounds every two weeks. We knew there was no problem with them (twin babies), so that was reassuring. That meant that I had fewer questions, since we really followed the development from week- to –week. We were reassured (woman at high-risk).

Comfort: Seven of the women received epidural analgesia. Not all of them were totally satisfied with the epidural and four out of seven reported some disadvantages, such as feeling pain during the injection, numbness on one side of their body, and the need to repeat the injection twice. Dizziness, lack of control during contractions, and second and third degree lacerations, were also reported. Most of the women, however, were satisfied with the consequences of the epidural as it meant pain relief. Observations of labours showed that most of the women were calm and relaxed, and even fell asleep between contractions. Some women were talking with their companions; and one of the women was even watching a movie with her husband. Most of the women who received an epidural considered it to be a humanistic approach to birth as it allowed them to enjoy their childbirth experiences more:

> **OB10:** Whereas once under epidural anesthesia, it is as if time stops and then we can ... And even yesterday, I know it has gone fast because the labour got done faster but I was able to live in the moment, to interact with people. So I answered your questions, we were able to talk, I could talk to the doctor, I could ask questions, I could be there in the action, otherwise I'd just have had a desire of "give me something" It is my conception of this relief, even to live it humanely, to live the present moment, to be present. Before that I was not present (woman at low risk).

One of the women said that:

> **OB2:** I felt pain, but it was less suffering than before. So after 15 minutes, it was good, I managed to calm down, because I was really excited. As I said, it calmed me down, and it helped me to sleep a little bit (woman at low risk).

Even if the perception of humanized birth by a woman, who received an epidural analgesia, was a birth without any medical intervention, but she felt that her childbirth was humanized:

> **OB9:** I understand the humanization of birth care as natural, no machines, [...] I would not be able for a normal delivery, I am not capable. Without an epidural, I would not be capable. I am afraid of pain, I do not like pain, I would never be able (woman at low risk).

The professional anesthetist believed that the epidural is a convenient factor for mothers, and a way to make birth more humanized:

> **Prof 10:** There are some people who say that an epidural (analgesia) is not humanized because it is not natural; it is an invasive technique in a certain way. But it is true that removing pain helps the woman, perhaps it makes her more ready to handle her baby (anesthetist).

Prioritizing saving lives over humanized care: Many of the professionals stated that in high-risk pregnancies, the most important thing for them is to provide proper care for the mothers, and to take good care of the baby:

> **Prof 11:** I guess we have to understand that when there is pathology, the care of mothers and babies it is more important (pediatrician).

> **Prof 1:** […] in a difficult situation, if the baby's heart decelerates, we must intervene quickly for the benefit of the baby. Maybe the humanization of care at that time could be given less priority… (nurse).

The professionals mentioned that they lose humanization of care during risky obstetric situations because they experience more stress, and they must respond more quickly. One of the professionals said that during these times they must concentrate more on the task at hand, focus less on the individual, and forget the patient. A nurse professional stated that: "it will all be too focused on the issue of the health of the patient rather than the human side". They emphasized that after going through an urgent situation, care should then be closer to the more humane-driven side:

> **Prof 5:** Of course when we have a woman with a high-risk pregnancy, it is harder to provide more humanization of care in the sense that there is an urgent stressful situation, so we do not necessarily have time to communicate with the patient. We act quickly, but after that, we tell (the patient) what we did. It is then afterwards (after the intervention) that I have time to explain to the patient what it was that happened (nurse).

An obstetrician emphasized urgent situations as a barrier to humanized birth as he stated that during these, he does not have much time to develop a confident relationship with the woman, nor have much time to explain everything:

> **Prof8:** I'm sure that my approach may seem outwardly, to be less humanized, because I'm pressed by time and I do not know the women. It happens in an emergency or where I have to take action to save her life and her baby's, so it's really an obstacle, it's hard to be human, to sit, to take the hand of the patient, to listen to her. When we must say things, such as "Madam, I must put you to sleep quickly, not five minutes from now", it's really a barrier that ensures that we cannot practice medicine as humanely as we would like (obstetrician).

Sometimes nurses were critical of themselves. They differed from – the doctors in this point of view that they believed even an urgent situation needed to be explained to the women and their families if they were supposed to be approached by a humanistic birth care plan.

> **Prof 5:** Sometimes we feel we should do everything quickly and without explanation. If we took just a few minutes with the patient to explain what we're doing to them, I think it would eliminate tension, and bring about a greater sense of security (nurse).

Non-stereotyped pregnancies in terms of humanized birth

Equality between pregnancies in term of humanization of birth: Most of the administrators and professionals emphasized that humanized care should not be limited to specific types of pregnancies, and that it must be considered in both low, and high-risk pregnancy cases. Most of the professionals acted in the same way towards both types of pregnancies, and believed that there is no difference between pregnancies when it comes to humanized birth care:

> **Prof1:** I think that whether it is a high-risk pregnancy, or a normal pregnancy, the humanization of care is a part of the process of pregnancy, it should not be stereotyped […], we should have the humanization of birth care for both […]. Whether it is a high-risk pregnancy, or a normal pregnancy, I think the humanization of care is part of the process of pregnancy; it should not be stereotyped (nurse).

> **Prof 7:** Honestly, I do not think it necessary to distinguish between high-risk pregnancy and low-risk pregnancy in terms of humanized care (obstetrician).

Some of the professionals stated that the humanization of care should not be something that is reserved for low or high-risk patients: "a person who is well has the same need as someone who is sick". Moreover, "low risk pregnancies should not be underestimated in terms of the humanization of care":

> **Prof3:** There is no real difference to me […] both (low and high-risk pregnancies) must be taken into account. Both have a precise path. There is one that perhaps brings a little more anxiety than the other, but how can I say it… both families must be taken in the same way, with the same importance, for a nurse. Families should only feel that they are being understood and respected, no matter if there is one who could lose her baby because the pregnancy is at risk as opposed to a pregnancy that goes well, the two cases should be considered important, otherwise it would seem unjust to me (nurse).

While almost all the professionals and administrators agreed with not stereotype pregnancies in term of humanized care, but in the same time some of them stated that the high-risk pregnancies "need to specific psychological and emotional care" and patients should "be informed of many things". As a whole, they agreed that humanized birth care in high-risk pregnancies means "to give exactly the same care, except put more stress on the high-risk pregnancies because of their health problems":

> **Prof4:** We just give more explanations to the person who has a high-risk pregnancy which is for her health and for her fetus' health (nurse).

Fig 1 about here

Discussion

Achieving the humanization of birth in a highly specialized hospital implies a profound reflection on the perceptions and values of its individuals meaning administrators, professionals, and the women, as the agents that guide the transformation of birth practices in the workplace.

The professionals and administrators' perceptions of humanized birth care in the studied highly specialized hospital mostly focused their discourse on personalized and family-centered care. The pressure of saving lives was considered as the biggest barrier in the provision of such care in the cases of risky pregnancies and deliveries. The perceptions of the women participants on humanized birth care, however, focused more on having security, and being assured by a competent professional. Besides this, having a choice, participating in the decision-making process, having good communication with the care providers, as well as being treated in a humane manner and receiving continued physical and psychological support, especially during labour, were considered to be the factors that facilitated the humanization of birth in the studied institution.

Most of the participants in this study addressed issues relating to safety and security. The available technology, the presence of competent and specialists care providers, and the presence of the neonatal intensive care units, were the most reassuring factors that brought satisfaction to all the women. The participants women felt that being treated in a secure and specialized

environment was a kind of humanized birth care, as it brought them both comfort, and peace of mind. Access to the competent professionals who were ready to provide a painless birth, and to handle all the potential complication was a great reassuring factor for them. Maloni et al's study (2000) revealed high-risk women's concerns for their own safety, as well as for their babies (Maloni & Kutil, 2000). Rutherford's study also revealed how the marketing of hospitals attempts to represent hospitals as an ideal place for birth, and how it rationalizes the hospital's environment as the best place for maternity care, while maintaining a promise to bring security, and to "re-humanize the birth experience with a sense of social bonding". Moreover, the presence of family and loved ones portrays the hospital birth experience as a familial event (Rutherford & Gallo-Cruz, 2008). It is finally undeniable that providing a comfortable Labour-Delivery-Recovery room (LDR), the 24-hour on-call anesthetist, availability of pain-relieving medications, specialists, and a neonatal intensive care unit, brought both security, and comfort, to the women participants at the studied highly specialized hospital.

The use of technology and medical intervention in the studied highly specialized hospital was not considered as a form of de-humanized birth care by the participant interviewees. The authors' previous study on humanized birth in high-risk pregnancies, in fact showed that 'humanized birth care is not a case of no medical intervention' nor does it oppose the use of technology alongside it (Behruzi, et al., 2010a). The clinical and medical interventions should be carried out while trying to understand the women's physiological and psychological needs (Behruzi, et al., 2010a; Campbell & Rudisill, 2006; Richter, et al., 2007). The participant managers in the Deslandes' study also emphasized the importance of having a solid 'technical competence' in order to be able to distinguish between unnecessary medical interventions, and those which should be considered under 'evidence-based' medical interventions (Deslandes, 2005). The literature has also shown that, generally, women's satisfaction with their birth has not been related to the absence of pain, but

with the ability to cope with pain through the support received from the care providers (Nagahama & Santiago, 2008). Noticeably, most of the women participants in this study also expressed that the pharmacological methods of relieving pain acted as a sort of humanistic care approach, as it relieved their pain and suffering, and allowed them to live through a better child birthing experience. In contrast, a common theme among all women participants in Dillway's study (2006) was " natural and unnatural childbirth as birth with or without an epidural" and women perceived epidural as a medicalized approach at birth (Dillaway & Brubaker, 2006). In Castro's study (2005), obstetric nurses did not consider the humanized birth as providing a childbirth without any pain , but rather one which included the use of natural methods of relieving pain, such as a water bath for women, etc (Castro & Clapis, 2005).

The findings of our study have revealed that life-threatening and emergency situations in the case of high-risk pregnancies act as a barrier to humanized birth by physicians in a highly specialized hospital. The literature shows that obstetricians have difficulty in providing humanized care for high obstetric risk patients where life threatening conditions arise (Behruzi, et al., 2010a; Hausman, 2005).

The participant women in the present study believed that in order to provide humanized birth care, the professionals should be caring towards the women and their families, and work from the heart, not merely carry out tasks. Richter et al (2007) concluded the same, and mentioned that caring for high-risk women can be improved if nurses gained more insight into everyday tasks (Richter, et al., 2007). Backes et al (2006) mentioned that humanized care is not a trick, or a tool, and that it is not limited to the interventional dimension, but it is more of a feeling of closeness, and manifests itself in their day-to-day activities at the workplace. He also showed that humanized care is not simply the technical assistance of patients, but also an understanding, and a caring for them as a whole (Backes, Lunardi, & Lunardi, 2006). Assuming that the

humanization of birth emerges simply as a more sensitive and caring approach towards women, the importance of the professional human's attitude and behavior towards implementing such a care in highly specialized hospitals is obvious.

The findings also showed that women perceived humanized birth as receiving good physical and emotional support by the presence of a care provider. Similarly, MacKinnon's study (2005) showed that women highly valued the support and the presence of their nurse during the intra-partum period. The meaning of the nurse's presence for women was simply to have someone there, someone to be with (MacKinnon, et al., 2005). In the study carried out by Hodentt (2006), labour support was defined as the presence of an empathic care provider who provides comfort, assistance, and information, and who helps women be more capable of coping with their childbirth stress (Hodnett, 2006). The literature has also shown that supporting and accompanying women during labour and delivery was considered a humanistic approach, as it enhanced women's psycho-emotional well-being and helped them experience less pain, and consequently a lesser demand for pharmacological methods of pain-relief (Davim, Torres Gde, & Melo, 2007; de Paula, de Carvalho, & dos Santos, 2002).

The findings of our study showed the possibility that decision-making by women, regardless of the level of risk threatening their pregnancy, was perceived as humanized birth care by most of the women participants. However, the professionals and administrators were not sure that the women at high obstetric risk could make the right decisions. The previous research by the main researcher of this study conducted in Japan showed the same findings. Interestingly, most of the professional interviewees in that Japanese study also believed that in the case of high-risk pregnancies, women lose control over their bodies, and are not able to always make an informed decision even after being given the pertaining information (Behruzi, et al., 2010a). Nevertheless, according to Deslandes (2005), administrators' and

managers' perceptions of the humanization of maternity care were based on the recognition of a patient's rights; it corresponds to care that is guided by respect, empathy, and listening. Patients' rights were considered to be allowing the pregnant woman and her family to receive continuous information about her health status, as well as information about the treatment offered to her and to her baby (Deslandes, 2005).

In our study, involving the whole family in the received care and the decision-making process, respecting the uniqueness of families, and providing a care that is responsive to the family's needs, was considered a humanized birth care approach by most of the interviewed professionals and administrators. These findings are similar to the Martine-Arafah et al (1999)'s study and its discussion on family-centered care in high-risk pregnancies which included factors, such as empowering the family, allowing the family to share the experiences of the illness, and encouraging the family to also provide care for the patient (Martin-Arafeh, et al., 1999). Previous literature has described family-centered care as care that is focused on the family rather than on the health care team through a common sharing of information and participation of both parties in the decision-making process (Martin-Arafeh, et al., 1999; Shields & Tanner, 2004). Promoting a family-centered approach of care for women at low and high-risk pregnancy thus seems like a reasonable approach that has been addressed in much of the previous literature (Leichtentritt, Blumenthal, Elyassi, & Rotmensch, 2005; Maloni & Kutil, 2000; Soeffner & Hart, 1998). Richter mentioned that since a high-risk situation affects the functioning and emotional life of the rest of family, their involvement in care should be respected in order to ease the pressure and stress on the entire family (Richter, et al., 2007). Similarly, the Thornburg study (2002) showed that women at high-risk should have an active voice in their care, and that all members of the family should be involved in the care taking of the baby (Thornburg, 2002). In another previous study by Gomes (2005),

sharing care has been described as "the humanization of care" while it comes to children in the hospitals (Gomes & Erdmann, 2005).

Our findings have shown that providing personalized care to each woman, is considered humanized birth care. Personalized care has been considered as one of the basic principles of humanized birth care in previous humanization of birth projects carried out in Brazil. It has been described as a woman's right to "have appropriate assistance for all her biological, social, emotional as well as psychological needs during pregnancy, birth, and the post-partum period" (Santos & Siebert, 2001). Personalized care allows a bond of trust to be formed between the care provider and the women who might be facing certain difficulties and/or abnormalities (Rutherford & Gallo-Cruz, 2008).

The findings of the present study have further been used to develop our primarily conceptual model of care, which aims to promote, protect, and support humanized childbirth in highly specialized hospitals. The key elements of humanized birth care in this context have been considered to be: provision of a secure and reassuring environment, recognition of women's rights regarding choices and the decision-making process, caring towards the women and their families, advocating and accompanying the women, centralizing family-care, and finally, personalizing care.

Finally, this study contributes to previous knowledge relating to the concept of humanized birth care in hospitals. The findings of our study may provide health care professionals and managers with a greater understanding of the issues surrounding highly specialized hospitals, and their importance for both women at low and high-risk pregnancy.

This study had some limitations. We emphasize that this study represents only the perception of participants on the humanization of childbirth

in one highly specialized hospital, and cannot be generalized to include all highly specialized level four or tertiary hospitals. However, the diversity of the participants in this sample helped us to explore the experiences and perceptions of humanized birth from many different viewpoints. Moreover, the primary author's background as a midwife and her previous knowledge on the subject of humanized birth represented in this case a facilitator in helping her accurately describe her reflections, and conclusions.

For future research on this topic, we suggest a comparison of the perception of humanized birth among different level hospitals. The authors have also suggested further research in tertiary hospitals, as well as further verification of the themes that have been unearthed in our study.

Conclusion

The perceptions of humanized birth in a highly specialized hospital cannot be limited to the key concepts discussed in the preliminary conceptual framework of this study, meaning the concepts of choice, control, continuity of care, and women-centered care, nor can it be understood without the mention of security, and reassurance. In our study, the notion of security was actualized to include having access to modern technology, high levels of monitoring, and expert professionals. Furthermore, continued presence of a care provider during labour, and reception of continued physical and psychological support by care providers was shown to be the best advocate of humanized births in such institution. Promoting family-centered care strategies in the sense of strengthening the family’s bond with the baby, participating in the care and sharing responsibilities whenever possible, as well as provision of a link of communication between family and care provider were shown to be facilitating factors for a humanized birth care approach in both cases of at low, and high-risk pregnancy in the studied highly specialized hospital. From the finding of this research, we conclude that a reassuring childbirth through a

high level of technology and expertise, as well as a caring approach and emotional and psychological support can be considered as best advocate for humanized birth in such an institution. Health care providers and managers will certainly benefit from the findings of this study, as it would promote the quality of care for childbearing women in the studied highly specialized hospital.

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Table1: Socio-demographic characteristics of women participants in interviews

Characteristics	N (10)
Age	
Minimum	22
Maximum	40
Mean	31.4
Nationality	
American Citizen	4
Canadian French Citizen	4
European Citizen	2
Education	
Secondary	1
College	3
University/college	6
Marital status	
Married	5
Single	1
Conjoin	4
Job	
Yes	5
No	5
Annual Family Income	
Less than $ 20,000	2
20,000 to $49,000	2
$50,000 and over	6
Number of deliveries	
One	6
Two	3
Three	1
History of abortion	
Yes	3
No	7
History of Previous Caesarean	
Yes	0
No	10
High-risk Pregnancy	
Yes	4
No	6

Table 1 : (Continue)

Characteristic	N (10)
Type of Complication During Pregnancy	
Twin, hypertension, preterm labour	1
Diabetes	1
Incompetent cervix	1
Fibroma	1
Non	6
Mode of Delivery	
Vaginal	7
Caesarean section	2
Operational vaginal delivery	1
Reason for Caesarean	
Failure in progress of labour	1
Planned caesarean for Fibroma	1
Epidural Analgesia	
Yes	7
No	3
Electronic Foetal Monitoring (EFM)	
Yes	9
no	1
Onset of Labour	
Not started	1
Spontaneous	2
Induced	7
Complication during labour or delivery or postpartum	1
Yes	9
No	

Table 2: Overview of themes (N=7) and categories (N= 12) emerged from the analysis of the interviews

Themes	Categories
Personalized care	- Care that is tailored for and responds to women's needs
Recognition of women's right	- The right to choose and participate in the decision- making process; - Women's right in high risk pregnancy
Humanely caring	- To have a more human manner - Good communication as a humanistic approach
Family Centered care	- Involvement of whole family in care
Women's advocacy and companion	- Comprehension and support - Companion and continued support
A compromise of security, comfort and humanity	- A secure, confidential and assuring environment - Comfort - Prioritizing saving lives over humanized care
Not stereotyped pregnancies in term of humanized birth	- Equality between pregnancies in term of humanization of birth

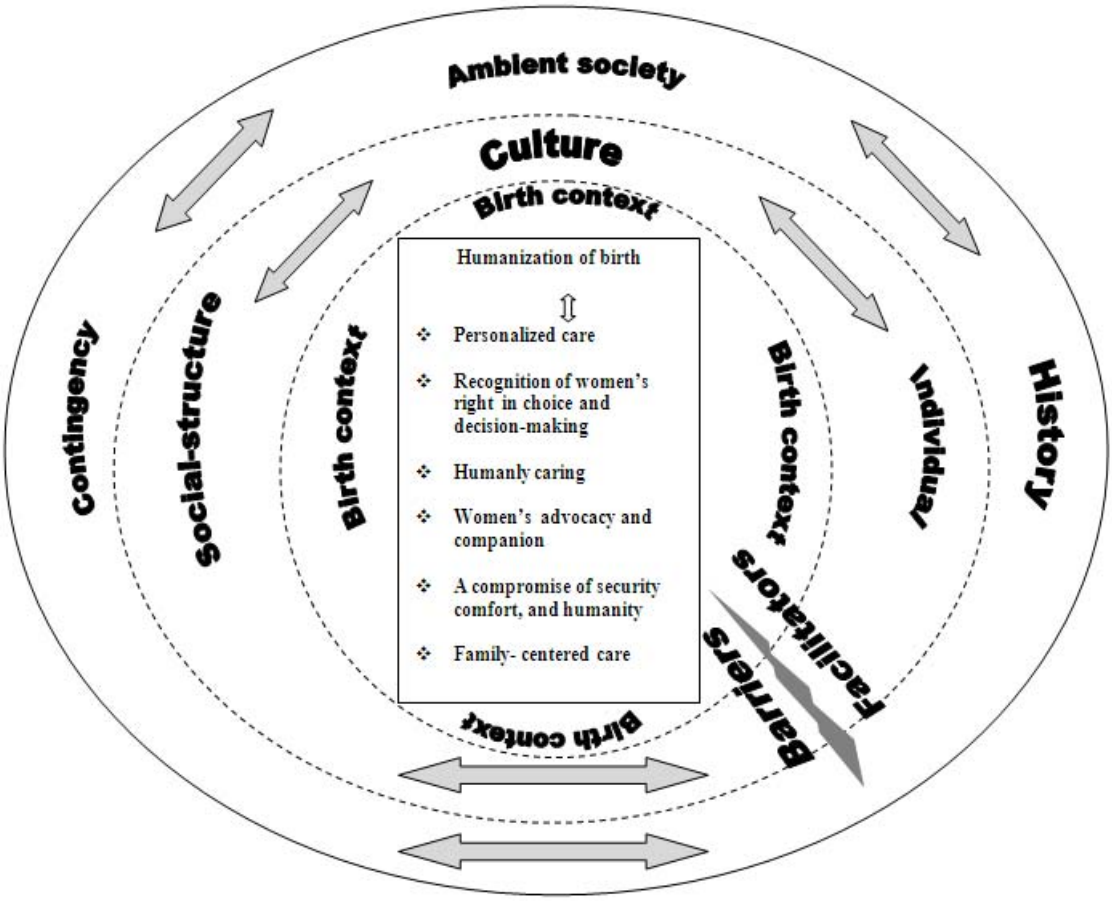

Fig1: Conceptual Framework for humanized birth in a highly specialized hospital considering Allaire & Firsirotu's Organizational Culture Theory (1984)

ARTICLE 3

THE FACILITATING FACTORS AND BARRIERS ENCOUNTERED IN THE ADOPTION OF A HUMANIZED BIRTH CARE APPROACH IN A HIGHLY SPECIALIZED UNIVERSITY AFFILIATED HOSPITAL

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Abstract

Introduction: Considering the fact that a significant proportion of high-risk pregnancies are currently referred to tertiary level hospitals; and that a large proportion of low obstetric risk women still seek care in these hospitals, it is important to examine factors that influence the childbirth experience in these hospitals, and particularly, the concept of humanized birth care.

Objective: The aim of this paper is to explore the organizational and cultural dimensions, which act as barriers or facilitators in the provision of humanized obstetrical care in a tertiary level, university-affiliated hospital in Quebec, Canada.

Methods: A case study design involving a single 'case' was chosen for this study. The study sample included eleven professionals from different disciplines, six administrators from different hierarchical levels of the hospital, and 157 women who had given birth in the hospital. The data in this study was collected through semi-structured interviews, field notes, participant observations, a self-administered questionnaire, documents, and archives. Both descriptive and qualitative deductive content analyses were performed and ethical considerations were respected.

Results: The findings showed that both the external dimensions of a highly specialized hospital (i.e. its history, society, and contingency) and its internal dimensions (i.e. culture, structure, and the individuals present in the hospital) can affect the humanization of birth care practices in such institutions, whether independently, or altogether. The facilitating 'external factors' found were: the humanized birth movement active in society, the vision of the key sector, and the managers of the institution concerning a humanistic approach to care, multi-institutional collaboration, and working in a network. The barriers

identified were the stakeholders' desire for specialization rather than humanization, hospital's roles (leadership and reference institution for obstetrical high-risk patients), and the shortage of health care professionals. The most important facilitating 'internal factors' were: the philosophy of the institution, its mission and strategies based on a caring approach, family-centered care, and science-based practice. All of these factors in turn reflected on the culture of the institution, and the practices of its healthcare providers. The most important barriers were limitations in the women's choice, communication barriers, the double-occupancy rooms, overestimation of medical performance and finally the presence of a lot of health care professionals.

Conclusion: The implementation of the humanization of birth practice in highly specialized hospitals aims at making the experience of childbirth more reassuring, comfortable, and pleasant for women and their families. A high level of technology and expertise, as well as a caring approach and family-centered care, are both necessary to ensure the provision of humanized care, as well as satisfaction of women who seek care. Highly specialized hospitals should thus examine the feasibility of introducing more options for women, and their right to make choices, if they aim to promote more humanized birth care practices.

Introduction

Childbirth is both a social and cultural phenomenon with political implications. It has changed dramatically in the twentieth century, both in developed and developing countries (Callister, 1996; Davis-Floyd, 1992; Rothman, 1982, 1989). Up until the end of nineteenth century, most women living in Europe and North America delivered their babies at home, often with the help of a midwife or a traditional birth attendant. Since the 1970s, hospital became the most common place for births. Many feminist activists have argued that the impact of the power given to male obstetricians, and their definition of childbirth, could lead to a belief in birth being a risky and pathological event in women's lives, and that women's beliefs and preferences at birth were two important factors responsible for the shift from home births to hospital births (Davis-Floyd, 1992, 1994; Hausman, 2005; Jordan & Davis-Floyd, 1993). Since the 1980s, increases in the rates of medical interventions at birth, such as the use of epidural analgesia, and cesarean sections, have also raised concerns not only among feminist activists with regards to women's right to have a 'natural' or 'normal' birth, but the Society of Obstetricians and Gynecologists of Canada (Beckett, 2005; Rothman, 1982; SOGC, 2008; Umansky, 1996).

In 2008–2009, the total and primary caesarean section rates in Canada were 26.3%, and 18.6% respectively (CIHI, 2010). Moreover, about two-thirds (69.0%) of all vaginal deliveries in Quebec, and 60% in Ontario, were preceded by epidural analgesia. Electronic Fetal Monitoring (EFM), which was originally designed for high-risk pregnancy, is used in up to 90% in recent years in Canada (Barbara, et al., 2002; CPSS, 2008), despite lack of evidence of its benefits. The total induction rate in Canada ranged from a low of 20.7 to a high of 23.7 per 100 hospital deliveries (PHAC, 2008). In North America, preterm birth rates increased from 6% in the early 1980s to 8% in more recent years, at least part of the increase the result of iatrogenecity (CIHI, 2007; PHAC, 2008).

Noticeably, women's request for caesarean section or for a pain-free birth, seems to have played an important role in the caesarean and epidural analgesia rates in past years (Beckett, 2005; Béhague, et al., 2002; Cindoglu & Sayan-Cengiz, 2010; Lazarus, 1994). Beckett (2005) argued that many women who choose cesarean section or epidural analgesia, may not be aware of the side effects of these interventions and are prone to make choices based on insufficient information (Beckett, 2005). More and more, women who choose hospital births and obstetric technology seem to do it out of concern for their baby's safety (Cindoglu & Sayan-Cengiz, 2010). According to Davis-Floyd (1994), American women who opt for the highest level of medical technology at birth, view these interventions as a form of control and empowerment over birth, rather than a loss of autonomy over it (Davis-Floyd, 1994).

On the other hand, it would appear that both high-risk and low-risk women were more satisfied overall when they were provided with a comforting, and humanized birth care approach in the midst of medical intervention (Behruzi, et al., 2010a). Previous research has also shown that the humanization of birth is does not necessarily involve restrictions on the use of medical interventions (Behruzi, et al., 2010a). These concepts describe the humanization of birth as consisting of: choice, control, and continuity of care. The previous findings of the same study (Behruzi et al., 2010) also revealed that the humanization of birth in a highly specialized university-affiliated hospital is in fact perceived through a different set of key concepts, these being: *security or safety, reassurance,* and *comfort*. These concepts were actualized for this setting by taking into account access to modern technology, high levels of monitoring, and professional expertise. In these institutions, *personalized care*, *women's advocacy, companionship, reception of continued physical and psychological support by health care providers in a family-centered context*, were shown to be the best advocates of humanized birth care.

Considering the fact that a significant proportion of high-risk pregnancies currently receive care in highly specialized hospitals; as well as the number of low risk women also seeks care in these hospitals, it becomes important to understand and explore the factors which may influence the childbirth experience in these hospitals, among them, the concept of humanized birth care. The humanization of care in a specialized hospital cannot be achieved if the external organizational factors, or its internal components is conceived separately. (Backes, et al., 2006).

We used the organizational culture model introduced by Allaire and Firsirotu (1984), in order to explore which of the external factors (history, society, contingencies) and the internal components of the institution (structure, culture, individuals); could act as barriers or facilitators to the humanization of birth practice in such hospitals. The authors considered the key concepts of humanization of birth as mentioned above.

The main research question was: regarding the internal and external components of an institution, what are the facilitators and the barriers that in a specialized and university affiliated hospital for adopting a humanized child birthing care?

Method

Study Design, Setting, and Data Analysis

The design is a case study involving a single hospital. The selected case is a highly specialized university-affiliated hospital in Montreal, Quebec, Canada. The hospital's reputation for providing care for women obstetrical high-risk individuals made a preferred tertiary level referral centre for high-risk pregnancy patients, as well as preterm and very preterm births and sick children in the province of Quebec. The case study is composed of three key

stakeholder groups that were considered in the study: 1) administrators, 2) professionals, and 3) women and families.

The study samples consist of: 1) eleven professionals from different disciplines including: nurses, obstetricians, pediatricians, and anesthetists, 2) six administrators from different hierarchical levels of the hospital, including: executive client-program management, quality and risk-assessment management, management of clinical services, and nursing care management, and 3) a total of 157 women who gave birth in the center during the study period

The sample size of the women was calculated to reach a confidence level of 0.95, a 2-sided interval, a standard deviation of 0.6 from a previous study (De Koninck, 2001), and a distance from mean to limit of 0.1 for a number of 139 participants. To cover the probability of drop outs, the total sample for this study was calculated to be 180 women.

The professional and administrative participants were chosen intentionally from different disciplines, and with varied levels of work experience, and the women participants in the questionnaire group were chosen randomly from the total sample. Ten women were recruited to participate in the interviews with a broad diversity in the pregnancy and delivery types.

For the women, the inclusion criteria were as follows: at least 18 of age, able to speak, read and write in French or English (necessary for completing the questionnaire). They had to be within 24 to 48 hours postpartum, they had to have given birth in the hospital; and finally, they had to give their consent in order to participate. Exclusion criteria included women with intrauterine death -this was due to the fact that such a condition may influence the childbirth experience.

Data Collection

Data was collected through: in-depth, open-ended, semi-structural interviews; field notes; participant observations; a self-administered questionnaire, documents, and archives. This variety of data sources allowed the triangulation of the data from the mentioned sources, and thus allowed us to obtain information on the individuals' behavior, not just their stated attitudes.

The interviews were conducted in French and lasted between forty and ninety minutes, and. The interviews were continued until saturation of data (Hardon, et al., 1994). All interviews with the women participants were conducted by the primary author in their postpartum hospital room, and these were voice recorded. An interview guide was prepared based on the conceptual framework and literature review. This guide had initially been pre-tested and validated before being used through separate interviews with two professional nurses and two women in birthing centres. The interviews were later translated into English for publication

The self-administered questionnaire that we used had been developed in the context of a study that assessed midwifery practice in Quebec, comparing it to the standard obstetrical care provided in the province (De Koninck, et al., 2001). The questionnaire was adapted for the needs of the present study and was written in both English and French. The questionnaire comprised four sections and ninety-four multiple-choice and open-ended questions. The questions covered the topics of maternity experience, health-related consultation habits, the pregnancy, and the delivery and after-delivery experience. Finally, the questionnaire also contained some additional personal and socio-demographic questions. The reliability of the questionnaire have been assessed by Cronbach's Alphas; its values ranged from 0.71 to 0.93 (De Koninck, et al., 2001). Several activities were also carried out in our study in order to maximize the validity and reliability of the qualitative findings. These

included methods, such as: obtaining coefficient reliabilities (≥ 80), triangulation of data, ensuring referential adequacy, persistent observation, and prolonged engagement (Maputle, 2004; Stake, 1995).

Ethics approval was obtained from the *Health Research Ethics Board of Hospitals affiliated with the Université de Montréal.* Informed consent was obtained from all the voluntary participants. The women agreed to allow the investigator be a observer during their labour and delivery, and for the first few postpartum hours. The women were informed that withdrawal from the study was possible at any time, that they had the right to refuse to answer any of the questions, as well as the fact that participation in the study would not in any way impact on the provided care to them. As regards data confidentiality purposes, the investigator used a code instead of the participants' names on the transcripts.

The data-collection period for this study spanned from October 2007 to March 2008, and it continued until a sufficiently rich description of the concept under study was achieved (Hardon, et al., 1994).

Data Analysis

Qualitative Data Analysis

In all, twenty-seven recordings were transcribed *verbatim* and checked for accuracy, then entered into the QDA Miner qualitative software (Package Version 3.2.3). The field notes gathered from the field visits, the observation sheets, and the archival and administrative documents were also entered into the same software. All transcripts were coded into their distinctive categories, and a deductive content analysis was subsequently performed on the data. This deductive approach aimed to validate and build upon the conceptual framework

and theory used for this study. Thus, initial coding began with the external and internal factors mentioned in Allaire's and Firsirotu's organizational culture theory, as well as some relevant previous research findings regarding the concept under study. Then, the investigator immersed herself in the data and allowed the themes and categories to emerge from the data (Patton, 2002). The data matrices were used to enable comparisons. A sample of matrices of the study shown in the data matrices were used to enable systematic comparison (Yin, 2003).

Quantitative Analysis of Data

The concept of *humanized care* as identified through the questionnaire's data means that the care has been modified to make it more in conformity with a certain philosophy and it was seen as being: *'care which is adapted to women's needs, that reflects a trust in the woman's capabilities, that gives control to women over decisions and choices,* '. The concept of *continuity of care* was assessed as being: *'the consistency in the content of follow up, such as: information, advice, explanations, etc*; and having '*no interruption in the care received e.g. different caregivers are seen; and care is a shared approach*.

Descriptive statistics (means and standard deviations for continuous variables and proportions of the categorical variables) were used to summarize the responses collected in the self-administered questionnaires. Special attention was paid to the description of the quality and quantity of services received in the hospital, obstetrical interventions and neonatal outcomes, as well as the woman's overall satisfaction with her birthing experience, and the control they thought they had over it. All statistical analyses were done using the SPSS software *(version 16).*

Results

The mean age of the participating professionals' was 44 years, (range - 23 to 56). The level of education for these participants was as follows: Bachelor's degree (4), College diploma (1), Masters in nursing (1), MD (3), MD and PhD (2). The mean age of the administrators was 49, (range - 38 to 60 years). Of these, four had a Masters in Science, one a Bachelor's degree, and one a DES in Health care administration. Two of the administrators had a background in nursing. A total of 157 women participated in the study. Of these, 58 (36.9%) had high-risk pregnancies The mean age of the parturient women was 31, (range 15 to 46 years). Most of women,83 (52.9%) were Canadian citizens of French language origin, had university level of education 95(60.5%). Most women (111 or 70.7%) were married and had annual family income equal or more than $65,000 (41. 4%). The socio-demographic and some childbirth characteristics of the women participants in this study are shown in table 1.

Table 1 about here

The analysis of data consisted of two main general categories: the facilitating factors and barriers. Twenty-one themes emerged from the context to describe the facilitating factors and eleven themes, which explained the barriers towards the humanization of birth approach in the studied highly specialized hospital (Table 2, Fig 1).

Table 2 about here

1. Ambient of Society

1.1. Facilitating factors: The humanized birth movement in society

Analysis of the narratives of the administrators revealed that the presence of various organizations and groups within society -such as the '*League La Leche'* have had an influence on the childbirth practice in Quebec hospitals as well as the studied hospital. The interviewed administrators pointed out that this group profoundly supported the rights of women and their families to seek humanized care, as well as using a variety of methods in order to ensure that the hospitals advance towards this direction. One of the administrators stated that:

> **ADM4:** when they come to hospital, and when we examine their advice, a lot (of our practice) becomes doubtful, and we can sense an interest in the idea of reviewing our practices (administrator).

Another administrator mentioned a '*parents-children'* association 'which has tried to work with the hospital in order that they may understand the way the hospital functions more precisely. He emphasized that this type of association leads health professionals to work differently, and in a more humanized manner. An obstetrician also referred to the humanized care movement carried out by feminist activists in Quebec as a facilitating factor for the humanization of birth practice in the hospital setting. He argued, however, that "major cultural changes have led to less pressure being applied nowadays by feminist movements, regarding the issues of humanized care" (Prof7). One of the administrators stated that the government of Quebec intended to consider the humanization of childbirth care in near future, however the humanized birth has not been defined in the governmental perinatal policy yet:

> **ADM1**: but I know that the spirit of this policy should go towards the humanization of care, de-medicalization of birth, the integration of midwives… So we know there is willingness in government and political sense. It should be released in the policy of 'perinataliy' in Quebec (administrator).

1.2. Barriers: Stakeholders' preference for specialization rather than humanization

The content analysis of the interview narratives collected in this study revealed that the extreme attention paid by the health care system and its decision makers to specialization and modernization is a factor which has led to the improvement in the quality of care by advancing the level of specialty and technology in highly specialized hospitals, as well as training more competent professionals to meet this change. The professionals interviewed concurred that the complexity of care, as well as the large proportion of diabetic and other high obstetric risk cases in the population, perhaps inclined decision-makers and managers to think more of the technical aspects of care, and not necessarily the humanist ones. The content analysis of the researched documents also showed that the vision of the health care system managers was mainly to provide specialized services and highly specialized care in the field of pediatrics and obstetrics-gynecology for all of Southern and Western Quebec, meanwhile the center of mother-child at studied hospital corresponded to 23% of the overall population of Quebec (Vision 2015).

2. History

2.1. Facilitating factors: Foundation of a children's hospital with a humanistic aim

Analysis of institutional documents showed that a group of volunteer female doctors had founded this hospital in 1907. The professionals stated that

the fundamental ideas behind the hospital and its functioning were humanistic, as well as being based on helping sick children. This was well documented in a book which recounted the hospital's history:

> **Doc:** Caring for sick children who are not accepted into other hospitals, working to control the terrible infant mortality each year, […] helping the poor and honest mothers who cannot provide their suffering children with the required care...this work is very humane (*Born, live, grow*: p21).

This hospital has is one of the largest pediatric centers in Canada, and it is a place in where its slogan is 'Pour l'amour des enfants' which roughly translates as 'for the Love of Children' (complementarily in pediatrics). In spite of being initially a francophone Roman Catholic institution, regulations in this hospital were adopted shortly after incorporation, making services available to children of all ethnic groups and denominations. Further document analysis also showed that about 25% of the children born in this hospital each year had at least one parent who had been born abroad (strategic plan 2007-2010).

2.2. Facilitating factors: Progress towards the humanization of birth in the hospital

Inspired by a humanitarian values, the organization was observed to become stressed by the maternal mortality findings and finally the doors were opened to women to give birth in the hospital setting (Born, live, grow: p18). One of the administrators mentioned that: "this hospital was one of the first hospitals to become a birthing center in Montreal"(ADM3). The content analysis of data showed that there had also been many changes towards the humanization of birth care since the establishment of the hospital. Almost all the administrators and professionals agreed upon the fact that having a *'rooming-in system'* or 'the mother and baby living together' was a facilitating

factor in the humanization of birth in the hospital, and that this system of care was not in practice before. The data from the questionnaires showed that 86% of the interviewed women had their babies in their room, whilst the other babies were kept in the neonatal care or intensive units.

Another noticeable change was the establishment of the *Labour-Delivery-Recovery (LDR) rooms* in the hospital, as well as the rule of *accepting a companion* in rooms. As one of the administrators pointed out: "the parents can stay here 24/7, they can sleep here, and their beds are set up for them. This was very restricted in past years" (ADM3).

This hospital thus became a *mother-child* reference center in North America in 2002, and it was described as a place where women could receive the best quality of care based on a *family-centered* approach. Promotion of *breastfeeding* strategies by experts, and the encouragement of mothers to breastfeed their babies, were also considered a facilitating factor by the administrators and professionals. The findings gathered from the questionnaires showed that most of the women interviewed were breastfeeding (72.6%), and most of them (86.6%) planned to continue breastfeeding. The majority of the women decided that they would continue breastfeeding for up to 6 and 12 months after delivery (table 1). Women's narratives also revealed the nurses' efforts to prepare mothers for breastfeeding: "nurses are pro-breastfeeding. They often came to help me, and they gave me information and advice" (OB1).

The hospital's movement towards *accepting normal pregnancy* was considered another facilitating factor by the nurses. The findings showed that most of the women (63.1%) who received care in the highly specialized hospital had a normal or low risk pregnancy versus 36.9%, who presented a high obstetric risk pregnancy. One nurse argued that this factor can bring normality to the midst of such a specialized environment, as well as ease stress

by aiding in the provision of a more humanized care for the women (Prof2). Another shift towards the humanization of birth in the hospital is the intention to *integrate midwifery services* into the hospital setting. One of the nurse administrators stated that they were aiming "to open at least four midwifery positions in the near future" (ADM3).

2.3. Barriers: A referral center with a leadership role

Analysis of the documents as well as interview narratives revealed that the previous and recent hospital leaders' views and values favored *keeping the hospital amongst the best places in the world to receive care* was in fact a factor leading to the development and implementation of more medicalized, rather than humanized care**.** Leadership roles were based on innovative care, and were recognized for excellence in academic teaching, and research in the hospital (Plan strategic for 2007-2010). Our findings revealed that the enthusiasm of the present leaders as regards the development of technology and the technical aspects of care - has actually caused an increase in the referral rates of high-risk patients to this center, and in consequence, it has led the entire hospital shifting towards a medicalization and specialization of care.

> **ADM2:** It (the development of the referral centre status of the hospital) marked the beginning of the medicalization of childbirth. Women were supposed to give birth at home, but these women could not (due to risk). So, there was a need for medicalization and specialized services for high-risk pregnancies from the beginning (of establishment of hospital)… So, this story is like the history of the medicalization of childbirth; it goes in the same direction (Administrator).

3. Contingency

3.1. Facilitating factors: Multi-institutional collaboration

Further analysis of documents and archives showed that the specialized hospital under study was an integral part of an Integrated Health University Networks (RUIS: Réseau Universitaire Intégré de santé) group based in Montreal. Twenty hospitals from eight different regions particiated in this RUIS which had as an objective to improve the *quality, accessibility, and continuity* of care to mother and child, as well to increase access for women and their families to advanced technologies, information, and to promote the harmonization of care practices (plan strategic 2007-2010; Director Plan, 2014, CHU).. Moreover, this hospital's offered home care to certain high-risk patients.

> **Prof 2:** ….we have already taken a step towards the humanization of birth. We have patients who prefer to be visited at home. There exists home care for high-risk pregnancies. They live in their environment, and we can provide good quality of care for them (nurse).

One of the nurse professionals argued that working in a network helped to maintain the continuity of care, as well to increase the continuity of information to provide to the mothers (Prof1). A woman stated that:

> **OB3:** I will meet a (community clinic) nurse. I hope for a good flow of information between the hospital and the home, because I know that after discharge, it will be difficult or impossible for me to re-contact someone here (low risk woman).

3.2. Barriers: Economic influences on humanized birth care

The narratives and data collected from documents, field notes, and interviews showed that there was a significant need for an external means of budget support in the hospital, in order to sustain its human and physical resources. One of the nurse professionals stated that: "the (budgetary) envelopes are protected for activities authorized in advance" (Prof5). One of the obstetrician professionals also stated that the health care system is in shortage of money which leads to establishing priorities and that lack of financial support by the government has forced the hospital not to place the issue of humanization as a top priority (Prof7). Obstetricians' narratives also revealed that, in spite of the fact that most of the money in the hospital has been invested on the physical security of the patient, a factor which has led to the reduction of the perinatal mortality rates in Canada to the lowest in the world, investment on the psychological aspects of birth care has in fact been ignored:

> **Prof7:** We must also regard the psychological health of women, children, and families; but I think the health care system currently has no resources to invest in this problem, and there is no initiative to finding these resources. I think the support on the psychological level in our country, is less than what is seen in other developed countries (obstetrician).

> **Prof8:** ….we are talking about high-risk patients who are faced with losing a child, or losing a pregnancy. There are very few psychological (support) resources in the hospital, so we cannot deal with these patients properly. This is a major obstacle to the humanization of care for these women (obstetrician).

One of the administrators also stated that, due to the shortage of financial resources, an early discharge policy had to be instituted. In cases

where the baby has to remain in the hospital to receive further care, the mother can be accommodated in a hostel that is located in the hospital (a specific place in the hospital) while. “You cannot keep them in their room with their baby because it costs $5,000 per day” (ADM3). The remuneration of professional staff also was considered among the most important issues in even to the point where it could influence the practice of humanized care:

> **Prof 4:** ….Of course, if the government gave fair wages to everyone working in hospitals, there would probably be higher quality care. When one is paid more or less adequate wages, it affects the service that comes with it… one feels a little bit abused if she/he is not paid well (nurse).

3.3. Barriers: Shortage of professionals

The shortage of staff, and the lack of accessibility to resources in certain circumstances, was considered one of the biggest barriers in the implementation of the humanized birth care practice in the studied highly specialized hospital by all the interviewed participants. One of the obstetricians said that: “it is sometimes a challenge to ensure the presence of a physician in a certain environment at the time of delivery” (prof7). A descriptive analysis of the data collected from the questionnaires showed that only 30 out of 157 (19.1%) had a choice of a care provider, and 7 out of the total of 157 women (4.5%) chose the hospital themselves; and that all the others were admitted by chance depending on the availability of doctors. Many of the women, including those at high-risk, declared that they had difficulty finding a doctor. The women participants in the questionnaire group responded to the question of why they did not choose a care provider themselves, as following: “we could not choose because there were not enough doctors”, “I was looking for a doctor and this doctor was the one available”, “It was controlled by hospital policy”, or “I was referred to this doctor”. One of the high-risk women stated that:

> **OB6:** I was not expecting to be followed at this hospital; there were so many requests. There was a waiting list too, so I was very lucky to be followed here (high-risk woman).

The shortage of physicians caused some women to wait for 4 hours for their prenatal visits, however, the mean waiting time was 46 minutes. The mean duration of prenatal visits was 31 minutes but it varied from 5 minutes to 3 hours, depending on if it was a first or follow up visits. One of the interviewed women expressed her unpleasant experience with having to remain in the emergency room for a prolonged period of time, whilst waiting to meet a physician for her child.

> **OB7:** I stayed in the waiting room for twelve hours… the problem of waiting exists in all hospitals. It is a generalized problem […] but the problem here was the lack of doctors. There were only two doctors who were in charge of consulting all the kids (low risk woman).

Further descriptive analysis of the questionnaires also showed that about 93% of women received care from obstetricians and gynecologists (33.8% male, 59.2% female), 3.8% from family physicians, and 2.5% were joint care providers. None of the deliveries were assisted by midwives in this hospital. One of the obstetricians argued that the regulations and decisions pertaining to the education of midwifery professionals, was the cause of this profession being marginalized and/or non-existent in hospitals:

> **Prof7:** The decision to educate midwives in an environment where there are no medical schools and where training is completely independent has marginalized midwives in the health care system[…] As long as there is no exchange between health care professionals, there will continue to be a gap between midwives, and other health care professionals (obstetrician).

4. Structure

4.1. Mission, Strategies, and Philosophy

4.1.1. Facilitating factors: The caring model and family-centered care

The analysis of data showed that the hospital mission and its strategies concentrated on a *caring approach based on the collaboration of family in care*. One of the administrators argued that:

> **ADM3:** "the caring approach yields a very respectful approach towards people and their needs" (administrator).

The findings from the questionnaires also showed that 80.9% of total women felt completely respected and accepted by the care providers. Most of women (47.8%) qualified the received care as a personalized or very personalized (42%), one which was adapted to their needs. The table 2 shows the quality of prenatal care received by women.

Table 2 about here

One of the administrator argued that their caring and family-centered philosophy, allows the family to act as a partner in care: "people are allowed to make informed decisions about their care, they make informed choices" (ADM2). From a total of 157 women, only 5.7% stated that they were not asked for their opinions, and 39 of 157 (24.8%) and 3 out of 10 interviewed women felt they did not participate in every decision that was made. Nevertheless, analysis of the questionnaires showed that most of the women participants in questionnaire group (81.5%) and 9 out of 10 interviewed women were not allowed to choose between different birthing positions, nor eat during labour (86.6%) if so desired. One of the women in the questionnaire group commented that she hid while she ate and it was frustrating not to be allowed to eat (QPID: 126).

A nurse professional argued that they try to prepare the patient to be as independent as possible, before giving them their leave. One of the nurses said that:

> **Prof 3:** We go with the principles of the family and then work with them more or less dynamically in order to act more as leaders, or a team coach, rather than simply telling the women what to do (nurse).

An administrator remarked that in a caring approach: “people do not feel a lack of service of physical care, but become more integrated and involved in the care activities themselves” (ADM5). The women interviewees mentioned that they had the feeling that they were at the center of care: “it is not the caregiver who is at the center; it is really the child, the baby, the mother, and finally the patient who is at the center” (OB6). The content analysis of documents also showed that the caring approach led to the creation of an environment in which the women had the opportunity to grow, learn, and adapt according to their own potential and experiences (Rapport annual 2003-4).

4.1.2. Facilitating factor: Evidence- based medical practices

The content analysis of data from field notes, observation, and interviews, showed that this specialized hospital had adapted its practices from general protocols and guidelines, which had been considered as evidence-based medicine. One of the administrator interviewees talked about ‘skin to skin’ practices as an example of this:

> **ADM1:** There are many things that we know about premature babies by means of skin to skin contact, or level of thermoregulation. It's not fair to say we prefer the "skin to skin" approach because it’s more fun (for

> the mother); there are studies that tell us that it is in fact beneficial (administrator).

A pediatric professional argued that personal decision and ideas had no place in their practice, or the implementation of protocols in child care:

> **Prof 11:** [...] many of these protocols emerged from guidelines that were written by the Canadian and American Pediatrics Societies. So no-one can actually say: we decided that for that child, or we want to do these tests. We can't do that (pediatrician).

4.2. Rules and Regulations

4.2.1. Facilitating Factors: Companionship and visiting rules

Almost all the women participants considered the companionship and visiting rules in the hospital facilitating factors in the provision of humanized care. Analysis of the questionnaires showed that most of the women had had a companion present during prenatal visits (55%), as well as labour and delivery (94.9%). Data from observation of deliveries showed that women could have as many companions in the LDR room as they chose. Most of the women (74.5%) in their questionnaires pointed that companion helped them a lot. The women participants affirmed that the humanization of birth is more prominent when the staff allows one to have one's close relatives nearby, especially during medical interventions or operations. One of the low risk women who received epidural analgesia expressed her feelings about having a companion during the epidural intervention as follows: "I really had to hold on to somebody in order not to move... I was glad of the support I had at the time" (OB2). A high-risk woman expressed her feelings about the presence of a companion during a cesarean section in the following way:

> **OB6:** It was reassuring to have someone there apart from all those people with their masks, their green coats, and caps […] to have

> someone close, a family member, just to hold their hand" (high-risk woman)

Narratives from the women and the administrators also revealed that there was no real barrier concerning neither visiting hours in this hospital, nor the number of companion and visitors present. The questionnaire showed that most of the women (91%) could meet their companion whenever they wanted. A low risk woman stated that: "the staff was very receptive...there is never anyone who says anything" (OB10). Another woman said:

> **OB6:** Evening visits, for example; they are quite flexible here because they allow the family to visit at any time. Of course with some precautions […] it is understandable that some parents cannot live without their child, or there are some who live far from the hospital, and cannot come earlier during visiting hours (high-risk woman).

4.2.2. Barriers: Discharge rules

Analysis of documentation from field notes and interviews showed that some mothers are urged to leave the hospital even if they are not psychologically and physically prepared, or have not received enough information. The nurses were generally in agreement that this discharge rule was a barrier to the humanization of hospital birth. One of the nurse professionals stated that: "some days you have to send the mother home. Everybody says: fast, fast, fast, and it's over. I'm sorry, but we also think this is inhumane" (Prof3). Another nurse said that:

> **Prof 1:** when we get a surplus number of births compared to the number of beds, our response may take away a little bit from the humanized care approach. Sometimes the discharges are signed for mothers, even if they are not necessarily ready to go. At this point, I do

> not feel very humane when I tell mothers: I'm going to pack your stuff up and take you to the front door (nurse).

The pediatrician's interview revealed that the early discharge rules come from the hospital's administration. She stated that: "administrators think in this way: do not occupy beds unnecessarily! They force us to sign a discharge after 48 hours, before twelve noon" (Prof11). The nurse professionals talked about their experiences with mothers who were made to leave their rooms and were temporarily accommodated in a 'the hospital while their children remained in neonatal care for medical reasons. "Mothers are crying and the parents are often split because of this situation" (Prof3). The other nurses emphasized that forceful discharge interrupts their teaching procedures: "how often have you heard that the (post-partum) education is not completed the day the patient leaves?"(Prof5)

4.3. The Professionals' Environment

4.3.1. Barriers: Insufficient communication and lack of teamwork spirit

Nurse professionals also saw the lack of communication between professionals as an important barrier in the provision of more humanized birth care. The nurses pointed to the lack of good communication between professionals in the childbirth and postpartum units. One of the nurses said that 'they seem like two different worlds' (Prof3). One of the nurses also stated that:

> **Prof 4:** As this is an academic center, the residents here are different for each discipline. So, sometimes all these people do not communicate well enough in order for everyone to clearly understand all the treatments needed for the women (nurse).

Another nurse said that “communication is not always clear between the nurses, we are not all aware of the history of the patient” (Prof5). She also mentioned that the lack of communication could be stressful: “sometimes the night shift person leaves and when we arrive, there is no report” (Prof5). Most of the nurses agreed on a lack of good communication between nurses and physicians:

> **Prof5:** Collaboration between the physicians and the nurses occurs mainly through the telephone, and it generally happens in cases of emergency… to ask them what to do (nurse).

The nurse professionals also mentioned that the overload of work prevents all the professionals from establishing a good level of communication; an administrator, in fact, said: ‘the barrier is actually the workload. Everybody runs, and everybody works hard’ (ADM3). Many of the women participants complained (in the questionnaire) about the lack of communication between their health care providers and said: “I’m complaining about the lack of communication between the units. When I arrived, my documents were still in the medical records department”; “during a change in shift, they did not bring me my daughter for breastfeeding, as they did not know they had to”; “the communication between nurses during the changing of shift was sometimes bad”; “communication between the night and day shifts should be improved.”

4.4. Training System

4.4.1. Facilitators: Teaching environment and humanistic approaches

The women’s narratives showed that they were more prone to being open-minded and collaborative with students, if the students had a humanistic approach:

> **OB3:** I feel I have complete confidence in these people (students). I was not anxious whether it was this person or another who assisted in my delivery. I was not stressed to not know these people; it was ok, because the people I met were friendly (low risk woman).

Other obstetricians and administrators argued that even if there were no written policies on the subject of humanized care in the hospital, the mentors at the university hospital could teach it to their students through their behavior. One of the obstetricians stated that: "in fact, we must teach humanized care ourselves. The students and trainees are around, and they watch us" (prof8). The pediatrician professional -who had a teaching role at hospital- emphasized that she tries to teach her students the humane side of care during training:

> **Prof 11:** I repeat my message to my students; I often say: "listen to how I talk with the nurses, how I talk with the receptionist, how I speak on the telephone, how I speak with the parents… do not just learn about diseases or how to examine the newborn, you must also work with all these people, and you must learn to respect them (Pediatrician).

The administrators concurred on the fact that their openness to humanized birth care alone, is not enough to bring about change in the birth practices, that administrators must take action to promote the humanization of birth:

> **ADM3:** It is not with rules that we change people, but with the influence of one another, and how we approach other people. If I'm next to the receptionist and I smile at a patient and I'm nice with her, I hope she (the receptionist) would learn to do the same thing. This inspires people to learn our ways in order to give the best possible care (administrator).

4.4.2. Barriers: Teaching environment and exceeded number of health care professionals

Analysis of data from the interviews, observations, field notes, and the self-administered questionnaire, showed that a teaching environment, and the presence of a large amount of health care professionals, can be considered as a barrier for humanized birth care as it can interfere with women's privacy as well as their families', a lack of intimacy, and a lack of continuity of care. Descriptive analysis of the questionnaires showed that some of the women (42.7%) had three to four care providers present during labour and delivery, and that about 24% of the women had five or more care providers at this time. One of the obstetricians stated that:

> **Prof 9:** we have a teaching environment. So we have the externs, the residents, the interns, also physicians and nurses, etc. and this is unfortunately a barrier to the humanization of care, because, for a patient, we are compelled to say her: "well, listen, we are in an academic environment, so for your delivery, there will not only be three doctors there, who are not necessarily yours, but the doctor in shift, and also a resident and also an extern, and perhaps also interns and nurses. It is unfortunately a bit contrary to humanization, but we have a duty to expose our students and residents in training, so that's a barrier: the educational environment (obstetrician).

Most of the women participants qualified the number of care providers present fairly (67.5%), and some qualified it too high (12.1%). Only 22 (14%) of the women had the same care provider who followed them during pregnancy during delivery, but even these came just for the birth of the baby. About 29.3% of the women said that it bothered them a little, not having their care provider with them during labour and delivery. Table 4 shows some descriptions related to the continuity of care in term of care provider during labour and delivery.

Table 4 about here

A high-risk pregnant woman said that: “a teaching hospital could be a disadvantage to humanized birth” (OB8), and another woman commented:

> **QP: 152** “in general, I am satisfied with hospital and I have received humanized care, except, we were disturbed a lot by the presence of a lot of care providers that did not consider our comfort” (woman participant in the questionnaire group).

One of the obstetricians stated that:

> **Prof8:** The presence of students could be a constraint for us; it could be preventing us from having better contact with our patients, as we always have an observer with us (obstetrician).

One of the nurse professionals talked about night shift students who do not always respect the families’ rest and sleep. She said: “sometimes people ask me: why do you wake me up all the time?” (Prof 5) The professionals’ concerns were mainly about the dignity and privacy of the women, and they stated that the environment constantly undermines their efforts for humanized birth, thus making it difficult for them to keep their calm. One of the obstetricians stated: “while nurses should talk to women who are going through a difficult time, with everyone entering the room constantly, it's impossible to keep track of the women” (Prof8), and an administrator mentioned that in high-risk pregnancy cases, the number of health care professionals is even higher. “When women are at high-risk, they become an interesting case to more residents, and there are more doctors who go to see them” (Adm6). Moreover, the analysis of data from observation and interviews showed that the frequent rotation of students and trainees was bothersome for the women and their families, as the women’s information would have been asked many times.

4.5. Physical Environment

4.5.1. Facilitating factor: Free accommodation for parents in the hospital

A hostel-like service in the hospital, accommodated parents for a week after the mother's discharge without any extra charge. Administrators and professionals considered the presence of hostel as a facilitator for humanized birth care because it "permitted parents to be hosted in the hospital and in proximity to their sick child" (Prof 4).

> **ADM3:** Having a room in the hostel for a mother who needs to remain somewhere to breastfeed her baby on demand, is part of the humanization of birth care (administrator).

4.5.2. Facilitating Factor: The Growing up Healthy Project

Analysis of documents also revealed that the implementation of a major project involving a physical expansion of the hospital, termed 'Growing up Healthy', aims to provide a friendly and welcoming environment to the mother and child. It aided the implementation of easy access to care and services, by re-organizing the physical structure and rooms of the hospital. This project let to the adoption of more space and services in the hospital for family cohabitation as well as the provision of rest areas, a kitchen, laundry services, a library, access to equipment information, etc.

Almost all of the administrators and professionals agreed that improving the physical structure of the hospital would help with the humanization of birth, as well as promoting quality of care. One of the administrators stated that:

> **ADM5:** It is well known that in a setting where the environment is pleasant, recovery is faster, and the child feels more comfortable. It promotes healing (administrator).

A nurse professional also stated that this project aims to "make the rooms more like birthing rooms or a familiar room, rather than a hospital room" (prof1). Some administrators said that the 'Growing up Healthy' project also ensures "the provision of double bed rooms where the spouse can sleep with his wife" (ADM3**)**, and "having single rooms with a modern vision" (ADM2). One of the administrators spoke of the fact that in the near future, there would be a dozen rooms adapted for labor, birth, and residence rooms, which are allocated to midwives (ADM2). Another administrator emphasized that the "Growing up Healthy" Project "Provides a more welcoming environment for the baby at birth, which is a very important step in the humanized birth approach" (ADM5).

The findings from the questionnaires revealed that for most of the women (72.6%), the site of prenatal visits was important, and most of women found it fairly hospitable (41.4%) or very hospitable (32.5), fairly friendly (46.5%) or very friendly (28%). However, some women (14.7%) found the visiting area fairly noisy, and 2.5% found it very noisy. When women were asked about their delivery room, most of them stated that they found it fairly hospitable (30.6%) or very hospitable (40.1%), and only 10.8 % found it fairly noisy or very noisy (5.1%). The interview narratives showed that the women participants concurred that the hospital had stepped into a period of renovation. One of the women said that: "in the interval between my two deliveries here, the delivery rooms have been renovated" (OB2). Data from the field visits showed that the hospital was undergoing a physical improvement. The administrators also emphasized the 'Growing up Healthy' plans to join the childbirth and postpartum units in order to alleviate movement from one side of the hospital to another (ADM5).

4.5.3. Barriers: Double-occupancy of rooms

During this study period, due to the lack of sufficient financial support, some parturient women had to share a room with another parturient woman in the postpartum unit. A nurse professional said that: “we place everyone who does not have insurance in semi-private rooms” (Prof1). Many of the women found the double rooms to be very inhumane, as well as uncomfortable. There was little space in the rooms, and it is always noisy and generally crowded. The women also complained about not being able to sleep at night. During one of the field visits, one of the women said that: “do you think this is humanized care? Not at all! We are considered as less than animals” (QP: 148). Most of the husbands also had difficulties staying with the mother at nights, since there was no space in the rooms to put a bed up for them. Moreover, the mothers felt that the double room put them in an uncomfortable situation. One woman stated that: “I am not a practitioner of religion, but I do not like to sleep in a room where there is another male companion present (QP: 148). One of the women participants explained that she had to change her room from a common room to a private one, since: ‘there was really such a chill there and there was no intimacy whatsoever’ (OB7).

A nurse professional mentioned that the rooms, which were shared between two women, were providing the contrary of humanized care, as they were the contrary of family-oriented care and intimacy: “it’s just a curtain separating the two people” (prof3), “we cannot talk loudly because we must respect the patient’s confidentiality” (Prof5). The nurse professionals also had difficulty providing nursing care for the women and babies in the double rooms: “there is not much space to bathe the baby, so we cannot get the nursery” (Prof5). The administrators emphasized that in the humanization of birth model, your baby is supposed to be close to you, while in this case, the

care providers are forced to take care of the babies in the nursery, since there is not enough space in the postpartum rooms. (ADM6, ADM2).

4.6. Management of Human Resources

4.6.1. Barriers: Lack of physicians, nurses, and midwives in the hospital

The content analysis of documents carried out in this study has shown that for a few years now, the shortage of nurses in the hospital has become a constant pre-occupation for its management. “Many action plans have been conducted in previous years in order to try to counteract this shortage” (Human Resources report). Almost all of the administrators and professionals agreed that preventing work overload by hiring more professionals can help in the humanization of birth care. One of the administrators argued that they needed more time to be able to provide that kind of humanized care: “the shortage of personnel causes work overload and stress, which in turn raises tiredness; and when you're not well yourself, it makes it hard to heal others” (ADM3).

The lack of family doctors, specialist nurses, midwives, and psychotherapists in the hospital, was considered as a barrier to humanized birth care by almost all of the interviewed participants. One of the women participants remarked in the questionnaire: “pregnancy is not a sickness, the midwife should be present in the hospitals” (QP: 70). The interviewed professionals stated that the lack of nurses and doctors make them overflow with work, and that under such conditions, it may take much longer before they can face the question of the humanization of care. One of the administrators said that many young mothers were not able to meet a doctor during the first 20 weeks of their pregnancy, even though many of them sought a doctor at this hospital; the hospital simply could give them an appointment (ADM6). The interviewed women participants were also aware of the shortage of health care professionals at the hospital, and its influences on the humanized care practice. One of the women argued that: “a large number of patients in a hospital where

there is not enough staff automatically lead to de-humanization. Why? Because overworking" (OB2). The professionals argued about the importance of removing specialists from normal pregnancies, and replacing them with midwives in the future. One of the administrators who agreed with presence of midwifery professional at hospital stated that: "I do not think we always need to have specialists in order to deal with people who have a normal health status" (ADM1). An obstetrician stated that:

> **Prof9:** It would require to first and foremost integrate midwives and general practitioners whose mission is to focus on pregnancies which are at a low or normal risk; whereas our fifteen obstetricians are trained, skilled, and motivated, either to care for high-risk pregnancies, or to do surgeries etc, not to have to monitor the low-risk pregnancies (obstetrician).

5. Individual

5.1. Ambient

5.1.1. Facilitating factors: Opting for the humanized approach to care

Analysis of data from interviews, observations, and field notes, showed that the professionals in this highly specialized hospital opted for the humanized approach to care. One of the administrators argued that:

> **ADM4:** for me it should just be careful when we have a job like ours, you really have to be careful not to fall into a highly medicalized approach where what is important is to make sure you have high-level care with the best, leading experts and ignoring all the human side (administrator).

One of the obstetricians stated that the medical intervention does not exclude humanized care for him and he is doing all monitoring and medical intervention very humanly (Prof8). The administrators seemed to show an

interest, in adapting different interventional protocols with the humanistic approach. Most of the nurse professionals expressed their willingness to provide a more personalized and humanized kind of care, in spite of the shortage of nurses, and the overburden of work and responsibility in the hospital. The pediatrician who was interviewed pointed out that even in the midst of a shortage of nurses, the nurses still tried to provide a gentle and human approach to the parents (Prof 11). A nurse also stated that they had excellent doctors and nurses in this hospital, who do 'the best they can'. However, "it's mainly the nurses who care about the humanization of care; and the ones who are the most sensitive to the client's needs" (Prof 4).

5.2. Needs

5.2.1. Facilitating factor: Receiving a pain-free birth

Further analysis of observations and field notes revealed that women needed to have the option of a completely pain-free labour and delivery. Almost 43% of women during prenatal care were found to be afraid of giving birth completely or somewhat, and some of the women felt would not be able to control pain none or less (26.1%) / or not really (14%). However, the analysis of the questions related to the women's feeling during labour showed that about 20% of the women felt not powerless at all or felt only somewhat powerless (28%) while many of the women were not sure about their feeling of power (28.7%) or control (29.3%) during labour. As a whole, 95 out of 157 (60%) of women (7 out of 10 interviewed women) had received epidural analgesia during labour, while most of them had used other methods of relieving pain, such as: medication, walking, changing position, breathing, and showering, before deciding to have the epidural analgesia. Even though many of the women experienced some mild side effects from the epidural analgesia, such as: dizziness, lack of control during contractions, and consequently, perineal lacerations; they stated that they were not disappointed with this method of pain relief. Most of the women participants in fact stated that they

were satisfied with their painless childbirth experience, and that they found it to be a humanistic approach to birth. One of women said that: “I demanded pain relief at my first, second, third deliveries” (OB9). Descriptive analysis of data from the questionnaires showed that both women who felt themselves powerless and those who did not, received epidural analgesia.

> **OB10:** It was my decision to have it as soon as possible. I was not for, or against it. I said, I will see how I feel… but when I started to suffer, I wanted to have the epidural, and I had a super nice delivery.

Interestingly enough, a multiparous low-risk woman who did not have access to epidural analgesia in her previous delivery, shared her regrets as follows:

> **OB2:** It goes back to 8 years ago, and there was not even this epidural option […]. So we did not have that option, in a general hospital, in where, I gave birth …we were not offered (epidural) in that hospital, so we had no choice. Birth was normal but again, it was terrible, it must be said! […] (This time) I did not want any pain. I've had enough. Well from that, I discussed with my husband more […] I suffered; I opted for the epidural (low risk woman).

5.3. Motive

5.3.1. Facilitating factor: Having a love for children

The professional interviewees emphasized that since this hospital was a specialized hospital for children, most of the people who work in it do it for the love of children: “I came here because it was a pediatric hospital” (Prof4).

> **ADM5:** The love we have for children is great. If you do not like children, in an environment like this, you cannot be obliged to do it. You should really love to heal people, because sick children need

> special attention. We should make the distinction that a child is not an adult; their behaviors are different (administrators).

The professionals also spoke about the volunteers who were in the hospital for the sake of the children. The administrators argued that working in a specialized hospital is demanding work, and thus care givers must really enjoy the environment, or the quality of care that is given to the mother and child in this setting. One administrator stated that he appreciated the care providing team, and emphasized that: "these people love what they do. For me it is important to have a team with good humor" (ADM3). One of the interviewed women stated that provision of humanized care depended on how much the care providers liked their work:

> **OB7:** "they must love their profession. If they have problems, or if they do not like medicine, no one could encourage them to do better in their jobs" (low risk woman).

5.4. Cultural Competency

5.4.1. Facilitators: Adaptive care providers and multiculturalism

The findings of this research revealed that the studied hospital hosted both Francophone and Anglophone customers in the Greater Montreal area, as well as clientele from across Quebec (Complementarily in Pediatrics). Narrative analysis showed that the professionals at the specialized hospital dealt well with the cultural differences which arose between the large numbers of immigrant clients at the hospital; especially when they were immigrants themselves. An interviewed pediatrician stated that**:** "they see that you are an immigrant like them, and it greatly facilitates the communication of messages" (Prof11). The obstetricians also agreed that the optimal care approach towards women is different depending on their nationality, as their goals are sometimes completely different. Due to this, the professionals must be able to adapt -or to

at least be aware- of this fact. The administrators spoke about Muslims being concerned about whether the care providers were male or female, and African women having specific preferences in the hospital. They also spoke about the importance of respecting families' cultural beliefs, and the attitude adapted whilst also adhering to hospital policies:

> **ADM3**: For example, if someone prefers that her baby does not get a bath until six hours after birth, for a thousand different reasons; we check whether it is safe for the baby or not, and if it is, we cancel it. Frankly, our care is always adjusted (administrator).

The nurse professionals argued that each woman has different desires, needs, and preferences, and that these must be respected. One of the obstetricians argued that how the care provider should adapt their approaches to Haitian, Muslim, and Jewish Orthodox, etc. and with their cultural diversity:

> **Prof 8:** So we may need to be able to be open just to better understand the women who live in different situations. A mother from Mont-Royal region is very different from the woman who is a refugee and lived in difficult situations in her country (obstetrician).

One of the nurses mentioned that having a frame of reference helps the caregiver understand the patient, instead of asking so many questions: "a frame of reference is something that explains where the mother comes from (which country), how things work in that country, and their principles and values" (Prof5).

5.4.2. Barriers: Language barriers

Analysis of narratives, field notes, observations, and questionnaires in this study, also revealed the fact that language barrier prevent women from

expressing their expectations, as well as their needs. The professionals' narratives revealed that some of them had language barrier problems as well:

> **Prof5:** We have many people here from different ethnic groups that do not necessarily speak English. The people who speak English only, however, are also a form of barrier for us because we have a hard time speaking English (nurse).

This finding revealed the communication difficulties present between the nurses, and the parturient women in the postpartum unit. One of the women's sisters -who could understand and speak French-, expressed her disappointment with regards to communicating with the hospital personnel. She stated that:

> **QP-147:** the personnel expected me to translate their descriptions to my sister. This was not right, though, because sometimes I really could not understand what they were saying (Woman's comments in the questionnaire).

One of the obstetricians argued about language barriers in the following way:

> **Prof 7:** Someone who speaks French fluently compare a person who speaks French with difficulty, or who does not know French, there will be a disadvantage to the latter when prompted to take decisions as there is no exchange (obstetrician).

Finally, one of the administrators argued that it can be painful for women to give birth in a hospital when they do not understand what they are told at all. The hospital documents have also not always been translated into other languages. Administrators considered these as barriers to the humanization of birth

5.5. Values

5.5.1. Facilitating factor: Valuing research

Some of the women participants expressed the fact that they valued research themselves, and most of them actually stated that they were participating in research in order to improve the quality of care for mothers and children:

> **OB1:** What is peculiar in this hospital is its research. We are often asked to participate in several research projects…and I agree to them. If it's for the education of future doctors ... I do not mind. And I do not think it is dehumanizing to be a participant in research, on the contrary, it can improve care, and the services we have for patients, babies, and moms (high-risk women).

One of the administrators argued about the importance of research in the perinatal field, and emphasized that research on the application of medical intervention during pregnancy can "ensure the viability of a child, and even the safety of the mother". Moreover, he stated that 'research which targets the humanization of care for clients can also facilitate this practice" (ADM5).

5.5.2. Facilitating factors: Valorization of the technology, specialization and humanized birth

The interviewed women valued the medical and specialization aspects of care. In fact, they valued both humanized care as well as medical intervention:

> **OB3:** The fact that this is a specialized kind of care and is thus medically driven was okay for me [...] I was expecting something humane as well as high levels of medical technology where no errors

> are committed if handled with serious and meticulous care. Maybe that can't be found anywhere else than here (low risk pregnancy).

Our findings showed that 62 (39.5%) of total 157 women (5 out of 10 interviewed women) were completely or somewhat ready for some kind of medical interventions; and only 12 out of the 157 disagreed with the medical intervention they received. None of the interviewed women disagreed with the perinatal medical interventions.

> **OB10:** I know other environments (hospitals), and I know some hospitals where the approach is less medicalized. I was less attracted to them, though, because I thought that here under any circumstances, I was in the right place (low risk woman).

The findings also showed that 98.1% of women had an Electronic Fetal Monitoring (EFM). With the exception of 2 out of the 157 women, all the women felt that they were safe, and that they had a competent care provider which was able to handle any unpredictable problems. One of the women interviewed stated that: "you feel a special care here, the staffs are very competent; otherwise, they might not have positions in a hospital like this, especially during deliveries" (OB2). Excluding three of the women, all the others felt that they were in good hands. One of the women who was pregnant with twins said that:

> **OB4:** I personally preferred to have access to all available care in case an urgent situation raised. I felt more confident coming here than going into a home birth (high-risk woman).

About 95% of the women- including all of the interviewed women- were satisfied with the care they received themselves, and that given to their babies. Most of the total 157 women (56.1%) and 9 out of 10 interviewed women answered that their delivery went better than they expected. Except for

9 out of the 157 (1 out of 10 interviewed women), all the women said that they would choose the same place for their next pregnancy if there would be any place for them. The common reasons expressed by the women participants in the questionnaires for choosing this hospital were: satisfaction with care, competence of the care providers, and the sense of assurance and security felt by giving birth in a highly specialized hospital for children.

OB9: I have had three pregnancies and it's (name of hospital) that I have chosen. I was more reassured knowing that this was a children's hospital rather than a general hospital […] they are there for the sick children. I did not expect any more than that (low risk woman)

6. Culture

6.1. Customs and Traditions

6.1.1. Facilitating factors: Familial festivities

Analysis of hospital documents revealed that this hospital adapted many customs and traditions, which aimed at helping mothers, children, and the whole family to have a pleasant hospital experience. The hospital benefited from its volunteers in order to achieve this goal. A specific "Children and Hospital" week is one of the customs of the hospital each year, and it involves volunteers organizing amusing activities for the children, as well as the parents:

> **Doc:** "Magic tricks, songs, games for children, juggling, and music; anything which will delight the young and old in all wards and outpatient clinics where they spend their time" (Complementarities in pediatrics).

Organizing family events, such as garden parties or "Fêtes Champêtres" was another tradition at this hospital. These were held on the grounds of the

hospital, and were organized for the enjoyment of the children and their parents (Rapport annual, 2003-2004).

6.2. Ideology

6.2.1. Facilitating factor: Dealing with patients' spiritual and religious beliefs

The administrators placed an emphasis on perinatal mourning, where they said they were confronted with different cultures as well as religions, and stated that the hospital was well adapted to the practices and different cultural beliefs of mourning. The administrators also stated that it was interesting that a hospital with a French-Catholic root had adapted its services for all kinds of cultures and religions. The data from field notes, interviews, and observations, showed that the team of care providers in the hospital was very skilled, and that they were able to adapt their interventions to be feasible regardless of religion:

> **ADM4:** We have a program of mourning. We train our professionals to be open to all kinds of cultural or religious reactions which they might be confronted with... We do all we can really do, in order to provide them with choices with which to deal with their deceased baby as they see it. Some people do not bring a priest, but bring someone from their religious practice instead, and they all gather in a room. We always try to adapt our interventions in concordance with the cultural or religious beliefs of the family under question.

The interviewed professionals and administrators mentioned that this hospital's customer profile had changed a lot, and that this had led to certain services having to be adapted. One of the administrators stated that the hospital offered spiritual support: "In the past, we had a pastoral service that was rather based on needs related to the Catholic religion, but now we no longer talk of religion" (ADM4). Moreover, women's narratives also revealed that they were treated with respect regarding their specific religions:

> **OB2:** Here, I had the privilege of being treated with no mention of my religion… everything was organized clearly, and due respect was paid to patients (low risk woman).

6.3. Symbol

6.3.1. Facilitating factor: A specialized hospital for children

The results of this research have revealed that this hospital is also well known as a children's hospital. The participant's narratives suggested that this fact acted as a facilitating factor for the humanized birth care practice. One of the high-risk women stated that: the care they give in a hospital for children are not the same as a general hospital's; "the services are also different" (OB9). Both the pediatrician, and the anesthetist interviewed, mentioned that in a children's hospital, the staff are always much more interested in taking into account the psycho-social aspects of care than in a general hospital. The pediatrician also said that it was because of their behavior towards children, that "many of the patients told me that they found care to be more humanized here" (Prof11). The participants' narratives also revealed that this hospital had a special place in people's hearts, as well as being well known as a referral hospital for sick kids:

> **Pro10:** This is known as a pediatric hospital despite the fact that we always say mother and child. But of course, people's perception changes when they consider it to be a good hospital (anesthetist).

A professional argued that this being a children's hospital affects their practice, and leads to the provision of more humanized care:

> **Pro8:** Walking and working around the hospital you meet sick children and parents, and you can understand them by looking into their eyes

> when they leave the operating room, because their little darling is undergoing surgery. When we see parents in the cafeteria with children who have oxygen bottles, I think this affect us too (obstetrician).

6.4. Values

6.4.1. Facilitating Factor: Valuing family

The content analysis of documents in this research showed that one of this hospital's prominent values was family. This value expresses the hospital's desire for the improvement of family well-being, as well as its responsibilities towards the family unit (plan strategic 2007-2010). The administrators and professionals interviewed collectively expressed the hospital's main values as being: "family-centered, and centered on women's needs", whilst others stated that: "the patient is one of the most important values" (ADM3). One of the nurse professionals spoke as follows: "Family is one of our big values; education is always related to the family. We focus on patients and in this way help them to be open to others" (prof5). The hospital also valued 'respect', which was stated 'must be reflected in the actions, attitudes, words and behavior of all employees, whether they are doctors, executives, or volunteers (plan strategic 2007-2010).

6.4.2. Facilitating Factor: Valuing research

Content analysis of the available documents showed that the CHU research centre in this hospital makes every possible effort in order to accelerate the development of knowledge in the fields of maternal, child, and adolescent care studies, to ensure a better quality of care for its population (CHU2002-3). Our results showed that this hospital, in fact, relied on its research center in order to identify approaches to overcome serious disorders observed in mothers and children, such as intrauterine growth retardation, obesity, diabetes, cardiovascular disease, etc. (CHU; 2002-3). Almost all of the

women participants were aware of the hospital's leadership role in research. One of the women said:

> **OB2:** We hear that a lot of research is being done here; there are many things that are said to come out of the research teams of this hospital. It's really a point of reference (Low risk woman).

One of the interviewed women argued the fact that even though this hospital was basically directed towards academic medicine and the development of science through research, in no way opposed its ability for the provision of humanized care (OB10). One of the administrators said that research is a priority for a hospital's reputation, and that: "if we do not have this option (research), we cannot be an appealing hospital to patients" (administrators).

6.4.3. Barriers: Valuing medical performance

Many of the administrator participants argued that the culture of care around high-risk pregnancies in specialized hospitals, and the highly esteemed medical aspects of this care, both act as barriers to the humanization of birth. One of the administrators stated the following: "this is a tertiary hospital, so we expect to have high-risk pregnancies, and babies that are the highest at risk. Everything is pointing in this direction" (ADM2). The administrators also agreed that working in a tertiary center meant resources which allowed for medical specialization, as well as skilled training.

The opportunities for the development of expertise present in this environment lead the physician to gravitate more quickly towards medical intervention. An administrator stated that: "there is no place for an unspecialized professional in high-risk pregnancies or for midwives who are trained for normal pregnancies" (ADM5). The obstetricians argued that "they

are valued for their medical performance, not for the fact that they listen to their patients, or because they spend time with them" (Prof8). They also argued that the hospital had been upgraded, and is valued by its effectiveness in having reduced waiting time in the emergency room and caesarean section rates, as well as increasing survival rates. This was not done for the humanization of care:

> **Prof8:** No-one gives us an assessment at the end of the month and asks us to look at ourselves and our patients and see where we have been humane…I'm told: 'you've had so many deliveries, and your forceps rate is this, and your cesarean rate is that. At that point we are evaluated and compared … The indicators of good performance are always expressed in terms of number of patients, number of births, number of emergency room visits, and the number of new cases being visited. This is rarely calculated on a measure of the humanization of care (obstetrician).

One of the administrators also stated that: "this is a tertiary hospital and we put priority on surveillance; this is not necessarily an environment which facilitates humanized care" (ADM2).

Discussion

By considering the core concepts of humanized birth care in a highly specialized, university-affiliated hospital, we have arrived at the findings of our study through the use of an organizational culture conceptual framework, as well as through the reflection of the barriers and facilitating factors related to the humanization of birth care in such a context.

To summarize, our finding showed most of the high-risk and low risk women were generally satisfied with the care and services they received in the

highly specialized hospital and they would return back to the same hospital if they had a choice. Our findings are similar to those of De Koninck et al (2001), in that approximately 88.5% of physicians' clients of in Quebec hospitals, indicated that they wished to deliver in same place for birthing if they became pregnant again (De Koninck, et al., 2001).

The finding of this study showed that feminist movements in the society, as well as 'La Leche League', still have some influence on the birth practices of hospitals. This group's aim is the well-being of women and families by means of bringing normality to birth, empowering women, and enhancing their autonomy as well as their responsibility towards their own pregnancy (Labelle, 2006). As a result of the cultural changes in society, however, there has recently been less pressure from these groups observed in the birth practices in Quebec. Recently, feminist movements have supported women's preference for the use of advanced technology at birth, as they argue it serves women's needs and purposes, even if according to Becketts (2005), many of the women who make the choice to have a cesarean section, or epidural analgesia, may not be aware of the side effects of these interventions, or make their choices based on insufficient information (Beckett, 2005)

The finding of this study also revealed that the shortage of care providers, such as nurses, physicians, midwives, and psychotherapists acted as a significant barrier to the provision of a more humanized kind of care in this setting. According to the Canadian Women's Health Network, Canada is facing a maternity care crisis (CWHN, 2006). The literature shows that the number of physicians in Canada who provide maternity care, accounts for less than half of all family physicians (CWHN, 2006). The number of family doctors practicing obstetrics is decreasing (M. Klein, 2000). The integration of midwives into the healthcare system, and their collaboration with other maternity care providers, could solve the problem of shortage of the practitioners in hospitals and improve the overall quality of maternity care as well as providing more

continuity of care, and achieving the best outcome for both women and children (CWHN, 2006; Fraser, et al., 2000; Schneider, 2002). The findings of our study have shown that the humanization of childbirth in highly specialized hospitals could also be facilitated by the provision of a psychotherapy service for women who are hospitalized and have complications, or for those who have lost their babies. It pays off to deal with women's anxieties, fears, insecurities, and depression, as well as those of their families. The contribution of psychologists in hospitals has been considered an important factor in recent years, as they help to heal not simply on the physical-biological dimensions, but also on the psychic, spiritual, and social dimensions (Mota 2006).

We have learned from the findings of this study that even though most of the women interviewed reported the positive experiences of childbirth, women in a highly specialized hospital are increasingly being faced with the medicalization of birth. The women participants valued technology and the specialization of care, and even considered it as a facilitating factor for the humanization of birth, as it brought them reassurance and comfort. It was clear for the women that a highly specialized hospital had its own frame of reference or 'language', and a highly technical one, and the women and their families acted in accordance with the values and technologies surrounding them. On the other hand, women and their chosen hospital had the same codes and language in care. In our study, almost the all of the women participants expressed no concerns about a natural birth. This contrasts with women who chose midwives or birth attendants as their care providers and who gave birth in a birthing centre. These women exhibited a resistance to the medicalization of birth, and opted for a natural birth, as well as seeking for continuity of care (Parry, 2008).

Our findings also showed that women had an increased tendency to want to give birth in a specialized children's hospital, as they saw it as being the best place for the safety and security of their baby. This result was similar

to one of the findings of Cindoglu's 2010 study, which showed that almost all Turkish women opted for medicalization due to their concern for a safe birth (Cindoglu & Sayan-Cengiz, 2010). Our findings also was similar to the study of De koninck et al (2001), where safety was considered as an important criterion for the quality of care for physicians' clients at hospitals and many women said that "if something goes wrong, we are in the right place"(De Koninck, et al., 2001). Hausman argued that the way birth is defined as a risky event, leads to the over use of medical intervention and technology by physicians, even in the case of normal births (Hausman, 2005). The medicalization of birth has come about due to the view that pregnancy as a time of risk and danger for the woman (Mitchell, 2001). The women who prefer technology and who rely on medicine and obstetrics, are more likely to consider the medicalization of birth as a means of reassurance, a reflection of the technological society, or finally as a result of fear as to the outcome of their birth (Henley- Einion, 2009). Henly-Einion has recently argued that "the concept of choice does not appear to be between natural and interventional birth, but between normal medical labour and complicated medical labour" (Henley- Einion, 2009).

Most of the participating women in this study felt that they could not go through labour and give birth whilst controlling their own pain. Thus, they requested an epidural analgesia in order that they may have a pain-free birth. Women found that epidural analgesia was a facilitating factor in the humanization of birth care. Our findings also showed that the presence of a companion and the emotional support provided by this companion, as well as the use of other methods of relieving of pain -such as massages and breathing- did not change women's decision to have an epidural. Noticeably, during the data collection period, there had been no whirlpool baths available in the hospital; however, during the last field visit to the hospital, this method of relieving pain was seen to be provided for the women. Nevertheless, most women still requested epidural analgesia for pain relief. Paradoxically, in

Parry's 2008 study, it was found that the Canadian women who chose a midwife felt they were more empowered than ever, and that they had full control over their bodies. Comparing women's quotes from Parry's study: "I just get the feeling that I can do this, and it's really not that big of a deal" (Parry, 2008), with the quotations of women from our study "I would not be able to deal with for a normal delivery, I am not capable. Without an epidural, I would not be capable of doing it; I am afraid of pain, I do not like pain, I would never be able", clearly shows the individual differences on these issues, as well as the variety of women observed in society, some of whom seek midwifery care, and some who choose highly specialized hospitals.

The literature indicates that women's fear of pain at birth is depended on how the women are prepared for birthing during prenatal care or even how they informed about it by around people. Empowerment at childbirth is relevant to midwifery care as the support of midwives is one of the most fundamental factors in a positive childbirth experience and help women to being in control of their body, mind and choices. The lack of support and understanding for the fear among those provide care during prenatal care and lack of enough information about the physiology of pain make women more dis-empowered (Nilsson & Lundgren, 2009). Melender's study (2002) showed that elements like previous experience, knowledge, or uncertainty caused fear to be associated with childbirth. Having knowledge found to be a very important means of removing or alleviating fear (Melender, 2002). The women participants in this study received information regarding pregnancy and childbirth through different meetings and prenatal classes, but it seems this information was not sufficient or supportive enough to overcome women's fears about birthing.

One of the facilitating factors of the humanized birth practice in this highly specialized hospital was seen to be the hospital philosophy, and the strategies, which had been founded on family-centered care. The family-

centered care approach of this hospital had already opened a door for professionals to share responsibilities with their patients, whilst still caring for their health. Our findings showed that women and families in this hospital were respected, and received a personalized kind of care. Previous research had shown that many women, who were looking for a midwife caretaker, were concerned about the 'individual' or 'personalized' and 'family-centered' aspects of care. In Parry' study, women discussed the importance of their husband's involvement in their childbirth; and they expressed their feelings that their husband wouldn't have been nearly as involved if they hadn't had midwives (Parry, 2008). However, the findings of our study revealed that integrating family involvement, and providing family-centered care, is also achievable in a highly specialized hospital, and that this was in fact a facilitating factor for the humanization of birth in such a context.

The findings also showed that professionals and administrators in highly specialized hospitals valued the humanization of birth, and were excited for the reconciliation of medical intervention and humanistic approaches to care. The humanization of care could be achieved through the validation of human beings, and one step towards this is "allying technical and humane competencies in professional practices" (Backes, et al., 2007).

Our findings revealed that changes have been made -or are going to be made- to the physical environment of the hospital and the maternity wards, in order to prepare for its evolution into a natural birthing centre, as well as to provide a more pleasant environment for women and their families during their hospital stays. Furthermore, many strategies were already in place -such as caring, involvement of family in care, breastfeeding strategies, and evidence-based practices, which were considered as facilitating factors to the humanization of birth. There were also still many barriers present, and these included women's choice limitations, lack of good communication between professionals in different units of the maternity ward, and lack of

communication between professionals in different work shifts. Language barriers, the existence of double rooms, and finally the presence of a lot of health care professionals raised questions on the issue of privacy and dignity, and continuity of care; then, these were also considered barriers for the implementation of a more humanized birth care approach. Mota et al (2006) stated that the humanization of care should be constituted as a policy in the organization of the health care system, based on the principles and modes of relationships between the professionals and the clients, and between the different professionals and different units of the health care services (Mota 2006). According to the national humanization policy in Brazil, humanization involves knowledge transfer between the health care providers and the clients, as well as between professionals and the ways their teams work together (D. S. Backes, M. S. Koerich, & A. L. Erdmann, 2007).

Finally, this research had a several limitations. We emphasize that this paper explores the facilitators and barriers towards the humanization of birth care approach in the studied highly specialized hospital, and findings cannot be generalized to all highly specialized hospitals. However, the diversity of the participants in this sample and applying many methods of collecting data enhanced the trustworthiness and accuracy of our finding.

For future research on this topic, we suggest a comparison of the facilitating factors and barriers towards humanized birth in the highly specialized hospitals, in different countries, where, the culture of childbirth is different from what we experienced in Canada. The setting of the highly specialized hospitals should be examined further for the feasibility of introducing more options for women, and for their right to make choices, if it aims at improving the practice of humanized birth care. More research should thus be conducted in order to understand what options and choices are realistically available to pregnant women who come to a highly specialized

hospital to give birth to their child, as well as the factors which women take into account when making these choices if there is possibility for it.

Conclusion

The implementation of the humanization of birth practices in highly specialized hospitals aims at making the experience of hospitalization more reassuring, comfortable, and pleasant, for women and their families. The findings of our study have provided us with a perspective on the organizational culture present in a highly specialized hospital, and its impact on the humanized childbirth experience. This perspective shines a light on the values, expectations, and assumptions that were favorable to the adoption of humanized birth practices in such an institution. From the findings of this research, we can conclude that a high level of technology and expertise, as well as a caring approach and family-centered care, are all necessary to ensure the provision of humanized care, as well as satisfaction of women who seek care in such an institution.

When the aim is to improve the humanization of birth care in the highly specialized hospitals, the question of educating more health care professionals and integrating more care providers, especially midwifery and psychiatric professionals needs to be addressed by the stakeholders in health care system and hospital administrators.

This is imperative if the stakeholders in health care system are to attempt to ease the present overload of work, and provide continuity of care ranging from the women's first antenatal visit to home visits after birth as well as offering psychological and emotional support to women. The collaboration between the Centre de Santé et de Services Sociaux (CSSS) that midwives are part of it, and hospital centres guarantees that not only the women receive

continued care, but also they would have access to different services and professionals in hospitals. This is what will enhance their sense of security.

In order to alleviate the fear of childbirth, and the feelings of loss of control experienced by women during labour and delivery, health professionals should focus on empowerment strategies, as well as preparing women for labour during prenatal visits, or even before their pregnancy. This would help women regain control over their bodies, reduce the level of distress they experience during labour and delivery, and thus avoid the overuse of medical interventions in birth, such as epidural analgesia, and cesarean sections. Author of this paper emphasizing on the fact that the mother, children and family must benefit of progress in obstetric technology, but still a balance between security and humanity is essential.

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Table1: Socio-demographic and childbirth characteristics of women participants

Characteristics		N=157 (%)
Age	Minimum	15
	Maximum	46
	Mean	31
Nationality	American Citizen	18(11,5)
	Canadian French Citizen	83(13,4)
	Canadian English Citizen	3(1,9)
	Canadian new immigrant	24(24)
	European Citizen	8(5,1)
	South America, Asia, Africa	21(13,4)
Education	Primary School	2(1,3)
	Secondary	20(12,7)
	College	40(25,5)
	University/college	95(60,5)
Marital status	Married	111(70,7)
	Single	8(5,1)
	Conjoin	36(22,9)
	Divorced	2(1,3)
Job	Yes	102 (65,0)
	No	55(35,0)
Number of pregnancies	≤2	95(60,5)
	3-4	52(33,1)
	≥5	10(6,4)
History of Previous	No	134(85,4)
Caesarean	Yes	23(14,6)
History of Previous	No	146(93,0)
complicated pregnancy	Yes	11(7,0)
History of abortion	No	114(72,6)
	Yes	43(27,4)
High-risk Pregnancy	No	99(63,1)
	Yes	58(36,9)
Mode of Delivery	Vaginal	102(65,0)
	Caesarean section	48(30,60)
	Operational vaginal delivery	7(4,5)

Table1: (continue)

Characteristics		N=157 (%)
Reason for Caesarean	Failure in progress of labour	12
	Planned caesarean	6
	FHR Abnormality	8
	Previous C-section	11
	Breech	5
	Medical indication in mother	3
Epidural Analgesia	No	62(39,5)
	Yes	95(60,5)
Electronic Foetal Monitoring (EFM)	No	154(98,1)
	Yes	3(1,9)
Onset of Labour	Not started	20(12,7)
	Spontaneous	74(47,1)
	Induced	63(40,1)
Complication during labour	No	142(90,4)
	Yes	15(9,6)
Complication during delivery	No	149(94,9)
	Yes	8(5,1)
Complication during postpartum	No	150(95,5)
	Yes	7(4,5)
The methods of feeding the baby by women	Breast-feeding	114(72,6)
	Bottle-feeding	21(13,4)
	Breast-feeding and bottle-feeding	22(14,0)
Women's desires to continue the breast-feeding	Yes	136(86,6)
	NA	21(13,4)
Family annual income	Less than 20 000 $	15(9,6)
	20 000 $ to 34 999 $	27(17,2)
	35 000 $ to 49 999 $	20(12,7)
	50 000 $ to 64 999 $	29(18,5)
	Over 65000 $	65(41,4)

Table 2: The emerged themes, sub themes, and categories from data analysis

Mega Themes	**Subthemes and categories**
Ambient of society	***Facilitating factors: The humanized birth movement in society***
	Barriers: Stakeholders' preference for specialization rather than humanization
Historical Factors	***Facilitating factors: Founding of a children's hospital with a humanistic aim***
	Facilitating factors: Progress towards the humanization of birth in the hospital
	Barriers: A referral center with a leadership role
Contingency	***Facilitating factors: Multi-institutional collaboration***
	Barriers: Economic influences on humanized birth care
	Barriers: Shortage of professionals
Structure	**Mission, Strategies, and Philosophy**
	Facilitating factors: The caring model and family-centered care
	Facilitating factor: Evidence- based medical practices
	Rules and Regulations
	Facilitating Factors: Companionship and visiting rules
	Barriers: Discharge rules
	The Professionals' Environment
	Barriers: Insufficient communication and lack of teamwork spirit
	Training System
	Facilitators: Teaching environment and humanistic approaches
	Barriers: Teaching environment and exceeded number of health care professionals
	Physical Environment
	Facilitating factor: Free accommodation for parents in the hospital
	Facilitating Factor: The 'Growing up Healthy' Project
	Barriers: Double-occupancy of rooms
	Management of Human Resources
	Barriers: Lack of physicians, nurses, and midwives in the hospital
Individual	**Ambient**
	Facilitating factors: Opting for the humanized approach to care
	Needs
	Facilitating factor: Receiving a pain-free birth
	Motive
	Facilitating factor: Having a love for children
	Cultural Competency
	Facilitators: Adaptive care providers and multiculturalism
	Barriers: Language barriers
	Values
	Facilitating factor: Valuing research
	Facilitating factors: Valorization of the technology, specialization and humanized birth
Culture	**Customs and Traditions**
	Facilitating factors: Familial festivities
	Ideology
	Facilitating factor: Dealing with patients' spiritual and religious beliefs
	Symbol
	Facilitating factor: A specialized hospital for children
	Values
	Facilitating Factor: Valuing family
	Facilitating Factor: Valuing research
	Barriers: Valuing medical performance

T**able 3.** Description of the quality of prenatal care

Criteria	N=157	%
The quality of follow-up during pregnancy		
Very complete	97	61.8
Complete	57	36.3
Incomplete	3	1.9
The care was		
Very personalized	66	42
Personalized	75	47,8
Impersonalized	14	8,9
Very impersonalized	2	1,3
Being in a good hand		
Yes completely	128	81,5
Yes somewhat	26	16,6
Yes none or less	3	1,9
Care provider was competent		
Yes completely	138	87,9
Yes somewhat	17	10,8
Yes none or less	2	1,3
Being respected and accepted by care provider		
Yes completely	127	80,9
Yes somewhat	27	17,2
Yes none or less	3	1,9
Being trusted by care providers		
Yes completely	115	73,2
Yes somewhat	38	24,2
Yes none or less	4	2,5
Encouraged by care provider		
Yes completely	114	72,6
Yes somewhat	34	21,7
Yes none or less	6	3,8
Not really	2	1,3
Satisfaction of care provider		
Yes completely	123	78,3
Yes somewhat	28	17,8
Yes none or less	6	3,8

Table 4. Description of care with regard to continuity of care during labour and delivery

Criteria		N	%
Women followed by the same care provider who had during pregnancy	Yes	22	14
	No	135	86
Women informed that the person who assist in delivery is not the same care provider who had during pregnancy	Yes	134	85,4
	No	21	13,4
	Missing	2	1,3
It was suit to the woman that the person who assist in delivery was not the same care provider who had during pregnancy	It suited me, fine	57	36,3
	I did not care	49	31,2
	It bothered me a little	46	29,3
	It bothered me a lot	3	1,9
	Missing	2	1,3
The presence of other health care professionals during delivery	Yes	133	84,7
	No	24	15,3
The frequency of changing health care attendant	Very often	15	9,6
	Fairly often	49	31,2
	Not very often	58	36,9
	Never	26	16,6
	Missing	9	5,7
The frequency of supervision throughout labour and delivery	Too frequently	18	11,5
	Fairly frequently	112	71,3
	Not very frequently	22	14,0
	Too infrequently	4	2,5
	Missing	1	,6
The number of care providers during labour and delivery	1-2	52	33,1
	3-4	67	42,7
	5≥	38	24,2
Qualification of the number of care providers	Too high	19	12,1
	Fairly high	106	67,5
	Fairly low	31	19,7
	Too low	1	,6
Would choose the same care provider for next pregnancy	Yes	139	88,5
	No	18	11,5

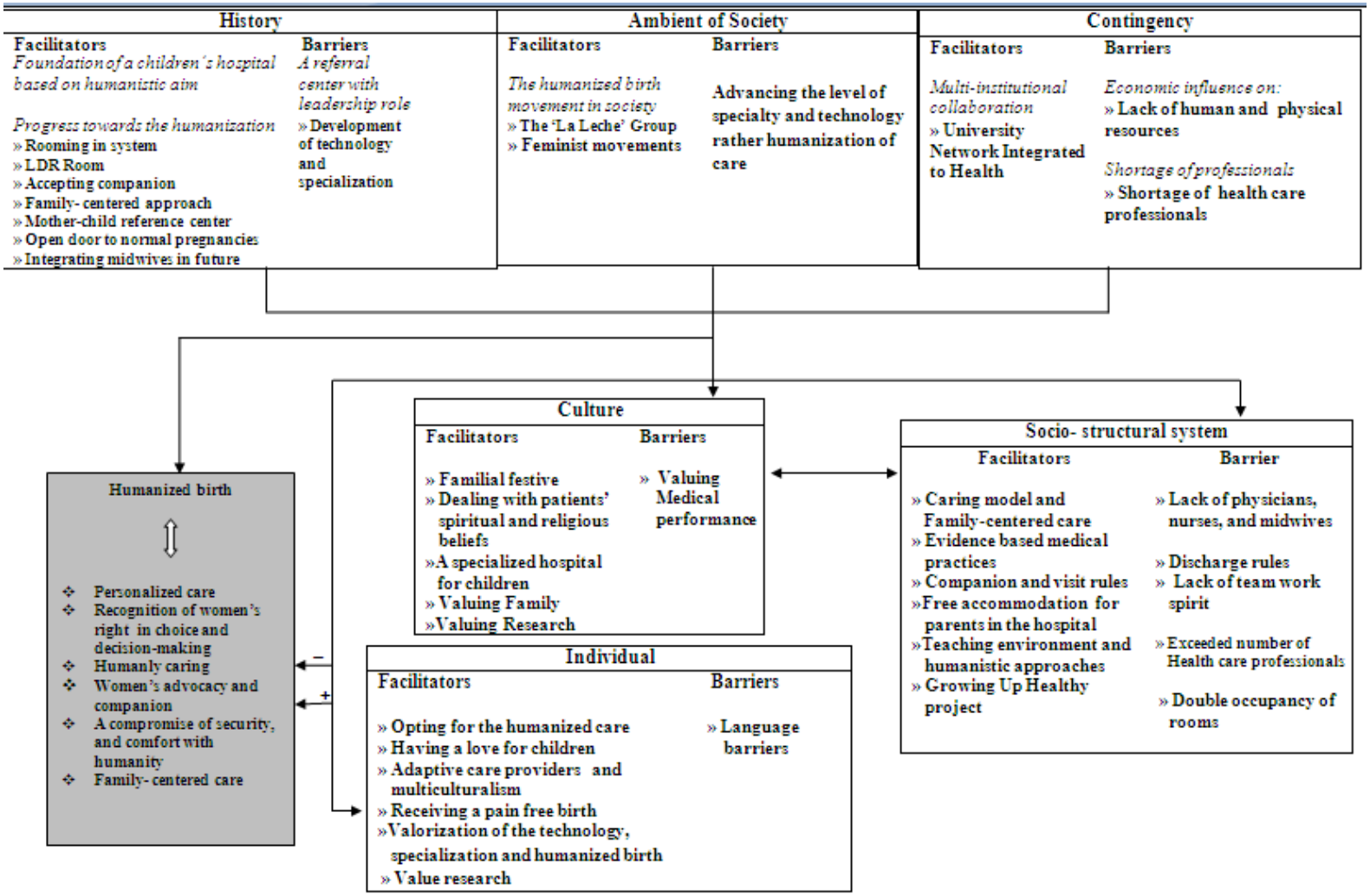

Fig1: Facilitator and barriers to humanized birth care in a highly specialized university affiliated hospital

CHAPTER V: GENERAL DISCUSSION

The aims of the present study are: 1) to define the specific components of the humanized care which can bring satisfaction to women seeking obstetrical care in a highly specialized hospital, and 2) to explore the organizational and cultural dimensions which act as barriers or facilitators for such a care approach.

The findings have revealed that women's perceptions of the humanization of childbirth in a highly specialized hospital setting focused mostly on security, safety, and reassurance issues. The professional and administrator participants' perceptions of the humanization of birth, on the other hand, were found to be focused more on the provision of a secure and reassuring environment for the women, as well as a personalized care that is tailored to the needs of women and their families. Family-centered care that covers the whole family was also found to be important for these professionals. Most of the participants in the study perceived the humanization of birth as a means of recognition of women's right to choose and participate in the decision-making process, treating women and their families in a humane manner, establishing a good communication between professionals, and providing advocacy, companionship, and continued support by the care providers. All the professional and administrator participants in the study agreed that the humanization of birth should not be stereotyped in term of low or high obstetric risk pregnancies.

Our findings also show that many of the components of the external and the internal environment of a highly specialized hospital can act as facilitating or preventing factors for the 'humanization of birth' approach. The greatest facilitating factors observed in the external environment of the hospital in the study were factors related to: 1) the *ambient* society, such as feminist activism and the concordance of the Minister of Health with the humanization of birth approach; 2) *contingency,* such as working in a network as an integral part of the University Networks Integrated to Health (RUIS); and 3) the *history* of the hospital, such as the humanistic aims of the foundation of the hospital, and its previous and present leaders' views on the promotion of hospital policies, and the implementation of changes which advocate humanized birth care. The most important external factors, which acted as barriers to

this approach, however, were found to be: the stakeholders' aspirations for specialization rather than humanization in highly specialized hospitals, the lack of necessary financial support from outside sources and a general shortage of professionals which lead to a lack of choice of a health care provider or a place of birth by women. Moreover, becoming a referral centers for high-risk pregnancies reinforced healthcare provider to the utilization of technical and medical obstetric care.

Our findings also revealed the internal factors observed in this highly specialized hospital which acted as facilitating factors in the humanization of birth practice. The greatest facilitating internal factors found were related to: 1) the s*ocio-structural* system of the institute -including its caring and family- centered model of care, its companionship and visiting rules, and its development of the physical environment of the hospital through its 'growing up healthy' project; 2) the *individuals* of the institution, such as the professionals and administrators' desires for the provision of humanized birth care besides of the medical interventional care model, their motives to work for the *love of children*, the cultural competency of the individuals to adapt to multiculturalism, and their value of the research being conducted on the humanization of birth, as well as their value of the technology and specialization of care besides humanized aspect of care which is tailored to improve safety, assurance, and comfort for the women; and finally, 3) the hospital's *culture*, such as its festive familial customs and traditions, its ideologies when dealing with the patients' spiritual and religious beliefs, having earned the symbol of being a children's hospital, and its apparent valuing of family. The findings of the present study also showed many of the internal barriers present in the humanization of birth care practice in the studied highly specialized hospital. These were found to be factors relating to: 1) the *socio-structural* component of the hospital, such as its discharge rules, its professional environment, the lack of sufficient communication among the professionals, the training environment of the hospital, the exceeded number of interferences, physical environment restrictions , such as double occupancy of rooms and lack of space, and its human resources shortage; 2) the

individuals of the hospital, such as language communication difficulties; and 3) the institutional *culture*, such as valuing medical performance.

In the following, we have brought some discussions on the findings of the study and tried to highlight the specific components of the humanized birth care that can bring satisfaction to women seeking obstetrical care in a highly specialized hospital (The first aim of this research).

Our findings reveal important aspects about the perceptions of the humanized birth care practice in a highly specialized hospital. These findings are similar to those of many of the previous research studies carried out on the perception of the humanization of birth in normal pregnancies. These studies showed that the key concepts of humanized birth are: family-centered or women-centered care, women's rights to participate in the decision-making process, and women's right to make informed choices. The findings of our study showed in turn that the humanization of birth is also perceived as a continuity of care in terms of the provision of continuous physiological, as well as psychological support by care provider which has already been described in the literatures (Brunt, 2005; Davis-Floyd, 2001; Harrison, et al., 2003; Misago, et al., 2001). The finding of a recent Canadian Perinatal Survey achieved by Maternity Experiences Survey (MES), revealed that only one-half (49.4%) of Canadian women had received continuous care in term of support from the same provider during pregnancy and at birth, while most of the women (88.4%) believed that it was important to have the same provider. (Dzakpasu, et al., 2008)

In almost all of the literature, the humanization of birth is defined as the use of decreasing levels of medical intervention in the normal delivery process (Brunt, 2005; Davis-Floyd, 2001; Page, 2000). In contrast to this, the humanization of birth in a highly specialized hospital is not, however, perceived in this way.

Women in this setting stated that they felt more satisfied when they were surrounded by specialists who humanely cared for them while at the same time they

used obstetrical technology and provided medical intervention. Most of the low and high-risk women participants in the study, perceived that giving birth under the supervision of a competent and expert care provider in a highly specialized hospital is a form of humanization of birth care, as it brings them a sense of safety, security, and assurance about their birth. Interestingly enough, the women in this hospital who were hooked up to the Electronic Fetal Monitor (EFM) and other monitoring machines, and had restrictions while walking with these, as well as changing position, had no complaints about their situation, and on the contrary felt more assured and secure. Increasingly, normal labour in highly specialized hospitals has been conceptualized as being a vaginal birth in which women are generally under electronic monitoring for observation of the fetal heart rate, as well as numbness from epidurals. Routine use of Oxytocin, is also seen to be used to speed up the process of labour. None of the low or high-risk women in our study, however, complained about the medical and technical care provided to them; and on the contrary, they found it to be a necessary element of a secure birth. None of the women expected the care providers to respect their bodies' physiologic capacity in giving birth without medical intervention.

The findings of our previous research on the concept of humanized birth care in high-risk pregnancy cases in Japan *(Annex XI),* showed that the humanization of birth care in these cases, in no way opposes the use of technology. However, none of the highly specialized Japanese hospitals had implemented strategies for the routine use of medical technology on normal pregnant women, or the provision of epidural analgesia on request. The cultural values and beliefs of the Japanese women studied in that research, as well as the obstetricians views regarding a natural birth, were found to be important factors in the promotion of the humanization of childbirth in the tertiary and Level 4 hospitals studied in Japan (Behruzi, et al., 2010b). Thus, we can conceive how the culture of a birthplace and its individuals can influence childbirth experiences in different countries (Davis-Floyd, 1994; Jordan & Davis-Floyd, 1993).

Considering the concept of risk being associated with the concept of pregnancy in modern obstetric, it is not surprising that these days, almost every normal labour includes the use of electronic monitoring of the fetal heart rate. Similar to the findings of our study, Henley-Einion argued in one of their studies that women in fact opt for having electronic fetal monitoring themselves, as they consider it as a means of reassurance (Henley- Einion, 2009). In Maloni's study (2000), high-risk women mentioned their concerns about the safety of their fetus, as well as their own health. These women worried primarily about the fetal outcome, and found that the hospital was the only safe place for themselves and their fetus in the case of a need for immediate access to medical care and technology (Maloni & Kutil, 2000). Even though it is well known that continuous electronic fetal monitoring does not improve pregnancy's outcomes (Impey et al., 2003), the technical and obstetric approach of monitoring women with machines seems to fit better with the pathological and technocratic model of birth care, as observed in the studied highly specialized hospital, and its shortage of care providers. In our study, care providers were found to be expected to follow hospital polices and specific protocols in order to reduce any unpredictable risks. Moreover, ensuring the satisfaction of women and their families by providing them with more technical care presented in humane manner was perceived to be the main care provider's solution to covering the humanized aspects of childbirth care.

Our findings showed that the humanization of birth in a highly specialized hospital was perceived as being a provision of companionship, as well as of continuity of care and support during labour and delivery. The women participants' definition of continuity of care mostly focused on the fact that it makes them feel as if someone is there if they need them. Continuity of care meant 'presence' for both interviewed women and the nurse professionals. The women participants stated a desire for somebody to assure them by their presence in the case of something going wrong. Page (2001) argued that the most important aspect of humanized care which a birth attendant can provide for a woman in labour is a constant presence, and the

provision of kind words and a gentle touch, as well as words of encouragement and reassurance (Page, 2000).

Moreover, our findings demonstrated that although the presence of a companion during labour was helpful for the women, it was still not fully satisfying. Some of the women experienced a feeling of loneliness and anxiety during labour, and thus preferred to have a nurse or a professional care provider as their companion. This finding is similar to that of a previous study published by MacKinnon(2005), which showed that the continued presence of an educated caregiver who provides clear information during labour, and who involves women in the decision-making process, can enhance women's overall satisfaction of the childbirth experience (MacKinnon, et al., 2005). In the studied hospital, as well as all other Canadian hospitals, the nurses were seen to provide most of the ongoing care to women in labour. Previous studies carried out at a university hospital in Montréal, Québec, have shown that nurses in Canada spend just 6 to 9% of their time providing labour support for women, as the nurse employees have many other simultaneous responsibilities, such as managing technology, and writing records, while all at once providing care for labouring women in a short-staffed environment (Gagnon & Waghorn, 1996).

The presence of a non-professional companion- such as family or friends- and the reception of emotional support, massages, and encouragement by the labouring women in our study, were perceived as important elements in the humanized birth care practice. However, these factors could not influence women's decision of receiving epidural analgesia. Matsuoka (2009) argued about the importance of providing one-to-one midwifery care and support to women in the reduction of fear of labour pain (Matsuoka & Fumikoa, 2009).The lack of nurse and midwife care providers, however, made it difficult for the studied highly specialized hospital to develop a policy and subsequent practice of one-to-one care during labour. Hodnett's (2007) study could not show any statistically significant association between the continued support of nurses, midwives, doulas, or childbirth educators and the

caesarean section rate in North America. However, continued support led to an overall reduction in the obstetrical interventions carried out, and the demand for medical methods of pain relief, as well as enhancing the women's overall level of satisfaction with their received care. Interestingly, Davies et al in their 2002 study, did not find any significant associations between the increase of time spent by nurses providing labour support, and a reduction in the use of EFM for the monitoring of labour (Davies, et al., 2002).

The findings of the present study have also shown that high-risk women felt that they experienced a more humanized kind of care when they were provided with honest information, and when their specific needs were taken into account. The high-risk women interviewed stated that they felt anxiety when they were not provided with precise information, or when the care providers seemed to be trying to hide the truth. Clear information provided during labour and delivery has been shown to facilitate an understanding by the women of the care provided to them, as well as enabling them with a greater amount of participation in the decision-making process (Kabakian-Khasholian, Campbell, Shediac-Rizkallah, & Ghorayeb, 2000; Nagahama & Santiago, 2008). Previous literature has emphasized that it is critical to provide high-risk women with information, by giving them succinct explanations of their condition, and reassuring their family members with rational hopes (Campbell & Rudisill, 2006). In a similar study to ours, Sittner et al (2005) also showed that high-risk women needed to have access to information, and needed to be informed of their plan of care without being scared. They also showed that when these women do not possess a true understanding of their condition, they cannot feel comfortable (Sittner, et al., 2005). Nagahama's study (2008) showed that receiving sufficient and adequate information was synonymous with humanization for women (Nagahama & Santiago, 2008).

Henley-Einion (2009) argued that in the medicalized model of care, women cannot make informed choices because the information that is given to them is controlled and restricted by the institution, as well as the health care professionals

(Henley- Einion, 2009). On the other hand, a true choice is not offered to women in any hospital, whatever level of specialty, and the only real options they are given are those related to the concept of risk, and those which define whether or not a woman can be allowed to have a normal birth.

Our findings explored many of those organizational and cultural dimensions that act as barriers or facilitators for the humanization of birth practice in a highly specialized hospital (the second aim of research).

The finding of the present study remarked that both women and professionals in the highly specialized hospital setting opted for the pharmacological methods of relieving pain and anesthetists were available in this setting at all times, in fact for the provision of epidural analgesia. Lee (2005) argued that use of non-pharmacological analgesia allows women to have more control over the delivery process. Paradoxically, the findings of our study showed that women in fact felt they had more control over their bodies when they received epidural analgesia. The need of women for chemical pain relief is thus not limited to highly specialized hospitals. Similar to the findings seen in the present study, Vadeboncoeur's (2004) study on the humanization of birth practice in a Level 2 hospital showed that about 40% of women were administered Nubain out of their own volition, and 26% of them had an epidural. It is not surprising to see that both the low risk women in Vadeboncoeur's study (2004), and the low and high-risk pregnant women in our study requested medical interventions, such as epidural analgesia since these two groups of women belonged to the group with a preference for hospital births -even though they did not have the choice of the level of specialty of the hospital- as well as having been acculturated into a 'pain free' culture of birth. Moreover, in Dzakpasu et al's study (2008), most Canadian women (81.1%) who had an epidural anesthesia believed that it was "very helpful."(Dzakpasu, et al., 2008)

In contrast to the present study, our previous research in Japan showed that Japanese women's cultural values and beliefs in non-pharmacological methods of

pain relief, made a large impact on this issue, and that these women experienced control over their bodies as a self-fulfilling, and a self-transforming practice (Behruzi, et al., 2010a).

Cultural values and attitudes acquired by women have an influence on their perception of pain as well as on their response to pain (Leeman, et al., 2003). Considering the findings of the present study, we find that the women interviewees in this highly specialized hospital who were mostly American and Canadian citizens did not consider labour pain as an important cultural and personal element of childbirth, as did the Japanese women interviewed in our previous study (Behruzi, et al., 2010a). Thus, the distribution for epidural analgesia among women who were of different nationalities (none were Japanese) showed that the organization in which the birth care is provided, and the availability of epidural analgesia without any external cost, could be acting as an important factor influencing women's decision to receive epidural analgesia. Contrary to all previous studies which considered the routine administration of epidural analgesia as an unnecessary medical intervention, and thus a barrier for humanized birth assistance, the administrator and professional participants in our study perceived this intervention as a facilitating factor and not a barrier for the humanization of childbirth. Surprisingly, Ito's 2002 study showed that Japanese women were less likely to accept epidural analgesia than American women when they were offered the choice of a painless delivery in an American birth setting (Ito & Sharts-Hopko, 2002). Furthermore, none of the women participants in our study believed that women grow into motherhood through their experience of pain, which was revealed to be a belief of Japanese women in Matsuoka's 2009 study (Matsuoka & Fumikoa, 2009).

The findings of our research revealed that most women were satisfied with the care they received during their perinatal period in the highly specialized hospital. The women's satisfaction was mainly related to the following factors: being in good hands, being well attended, receiving good service, undergoing a painless or

relatively painless childbirth, and having no complications at birth. Moreover, the presence of a competent professional who is able to provide a caring and humane manner of assistance during labour and delivery was identified as a major cause of satisfaction relating to the childbirth experience by the women. This competent professional can bring about a painless birth, as well as assurance to the women. Our findings also show that in a highly specialized hospital setting, when a care provider makes a bond with a woman, she feels welcome and cared for. This in turn increases her satisfaction. These aspects of humanized birth are evident in the debate about women's satisfaction regarding the public health care services explored in Hotmisky's study (Hotimsky, Rattner, Venancio, Bógus, & Miranda, 2002). On the other hand, almost all the women participants in this study were content with simply having the support of their partners or family members during their pregnancy and childbirth. Previous research has also shown that provision of support for women during pregnancy and labour is a largely important factor in women's satisfaction of the childbirth experience, since women can be emotionally and physically fragile during these periods (Dias & Deslandes, 2006).

The women participants in our study stated that they felt very lucky that by chance they had found a place to give birth to their baby in a highly specialized hospital. As shown previously, however, these women had no "right choice" when it came to choosing their birth place or choosing their care provider, and they often complained about the difficulty to access to hospital resources available to them, especially those with a better reputation, such as the hospital under our study. Moreover, a shortage of care providers and an overload of work made women wait long hours for their appointments.

High-risk pregnant women are often transferred by health care professionals to other facilities, which provide them with specialized care, tailored for their cases. However, these professionals do not always take responsibility for ensuring the women a place in the hospital before referral; these transfers are often made verbally, and women have no guarantee of obtaining a place in the specialized hospitals. The

greatest distress exhibited by women in this studied setting, was due to their hopelessness in having a guaranteed place for delivery before the onset of labour. Many of the low-risk pregnant women also stated this as being a factor of stress for them. Dias et al's study in Brazil, showed that Brazilian women found it inhuman and cruel to have to continuously be faced with uncertainty and anxiety about their appointed place of birth (Dias & Deslandes, 2006).

Clinical Relevance of this Study, and Implications for Future Studies

The present study succeeded in clarifying the organizational and cultural barriers and facilitators, which influence the humanization of birth practices in the setting of a highly specialized university-affiliated hospital. The findings would help to improve maternity and childbirth care with an emphasis on the empowerment of women and the humanization of birth. They would be useful to clinician obstetricians and gynecologists as well as midwives, nurses, and health providers, in general. By being aware of our findings, these professionals would be better informed about the institutional and cultural barriers and facilitators present in the establishment of a more relevant humanized birth care practice in the hospital, as well as the optimal provision of quality support for childbearing women in the context of a highly specialized hospital. Therefore, the findings will assist the health care providers in the promotion and organization of mutual participation between themselves and the women from the beginning of a pregnancy until its end.

The present study has provided a comprehensive conceptual framework of the relevant factors present in the humanization of the birth practice. This framework could help managers and stakeholders to identify the factors that may need close attention to achieve better overall health care services in highly specialized hospitals. Considering that all organizations are faced with a challenge of growth, development, and effectiveness, we hope that this contextual model will help managers and leaders of these institutions to identify specific actions based on their organizational needs.

The present study will also be of interest to the Ministry of Health of Quebec, stakeholders, and healthcare decision makers. It recommends a reorganization of the prenatal and labour care programs in the context of highly specialized university-affiliated hospitals towards a more humanized approach. Following this reorganization, women in such specialized hospital settings would receive a more humanized birth care that respects their level of pregnancy and delivery risk, as well as their expectations; and the myth of dehumanized care in highly specialized hospitals will finally be lifted. The proposed conceptual framework could be further refined in future studies. This could be pursued further by conducting the examination of these factors in other highly specialized hospitals, such as General Jewish, Royal Victoria, and St. Luc, etc.

The findings have enriched the knowledge of the subject of humanized birth care, not only in the case of normal pregnancies, but in high-risk cases as well; and more importantly, it has gathered information about an environment which is well known for its high level of technology and specialty. High-risk pregnancies by themselves bring about sufficient conditions to induce stress and feelings of insecurity in women, consequentially, the loss of women's emotional control over their bodies, and the trust they put on competent care providers and technology is evident. It was interesting to find out the source of insecurities in low risk pregnancy women in this study, and their reliance on obstetrical technology as well as their desire to give birth in highly specialized hospitals.

There is no doubt that the evolution of care during pregnancy and childbirth towards a more humanized approach is critical to enhancing the overall quality of obstetrical care in highly specialized hospitals. The humanization of birth care approach cannot be guaranteed without first knowing the leaders and decision makers' opinions on the matter, since they comprise the upper level of hierarchy in the health care system, and it is them who arouse the mobilization of all the actors

involved in maternity care. We also suggest that more studies need to be carried out on the issue of the humanization of birth at the level of a Minister of Health, and that this type of research should be carried out further in other tertiary or fourth level hospitals.

Many of the barriers encountered towards the humanization of birth care are related to a lack of healthcare professionals or a lack of enough places or positions in hospitals for those who are about to finish their training. Addressing the shortage of nurses, obstetricians and other human resources personnel in hospitals, and consequently, the lack of continued support for women during labour; it is clear that more studies need to be conducted in the future in order to explore the factors which are acting on training and integration of nurses, as well as midwives, in highly special hospitals. Midwives are specialized professionals, and are known to be the best advocates of humanized birth in normal pregnancy cases. These professionals could provide continued support for low risk pregnancies in the highly specialized hospital setting, which is the task of perinatal nurse professionals now. According to the latest released Quebec perinatal policy, in 2008, women should not only receive continued care, but they should also have access to different services and professionals in hospitals which enhance their sense of security (MSSS, 2008). The midwifery philosophy of care -which emphasizes on being with the woman, and one-to-one care- must at some point shape health policy. In order to influence health policy in a highly specialized hospital, however, midwives must be integrated into such an environment –a case that is observed in Japan and many other countries. More research should also be carried out on this issue in order to advocate the humanization of birth in highly specialized hospitals, as well as improving the outcomes of pregnancy and childbirth.

The strength and limitation of the study

Using a mixed quantitative and qualitative method of collecting data, and the collection of an excellent variation of samples provided a rich pool of data to the study. The observation cases were only ten, but it covered two cesarean sections, one Vacuum-extraction assisted delivery; and a twin birth! The interpretations of the findings are shaped on the basis of triangulation of four sources of data, as well as of our in-depth knowledge in this field. However, this study, as any other, has some limits.

There were some findings in this study about high-risk women who experienced bed rest during their prenatal period, but the data were not sufficiant for processing. On the other hand, data from the interviews and questionnaires were not sufficient to allow the findings to be presented in our results. Furthermore, the findings cannot uncover whether these were the women's culture, and/ or the culture of birth place, or if the availability of obstetric technology, and the easy access to epidural analgesia - which is covered by insurance policies- that resulted in the high rate of demand for epidural analgesia observed in the studied hospital.

We tried to describe the research methodology including sampling, methods, and analysis in detail, which was used - to increase the transferability of the findings. The nature of this study, however, does not allow generalizing findings, as they do not reflect the practices of all obstetrics departments, in all highly specialized hospitals, regarding the humanized birth care issue in the province of Quebec in Canada. The level of obstetric interventions in different hospitals could change according to the hospital's mission, the level of care offered in that setting, and the characteristics of its target population.

Contributing to the theoretical foundations of organization of care

To provide maternity care of optimal quality, public health stakeholders need to be aware of the childbirth practices in different organizations and then assure that it conforms to women and their families' need. In cases where performance fails to meet the women's need, making attempts to modify or improve the organization, as well as changes in the care provider's behavior seems necessary. The theoretical framework of this study may not be broad enough to allow analysis of all the organizational dimensions and their influences in providing an optimal care, but at a theoretical and practical level, it still has the potential to highlight some components of humanized birth care and the facilitating factor or barrier into such a care in a highly specialized hospital. Our findings in this study have developed based on rigorous analysis of data, thus, the highly specialized hospitals may well make significant advances in the quality of care and services offered to women and families through the application of the findings of this study.

Imposing an organization of care in the highly specialized hospitals with the philosophy of humanized birth, modification of the rules and regulations in order to provide continuity of care, evolving the mechanisms of budget allocation to the hospitals for reassuring financial and hiring human resources and proposing closer cooperation in professional levels between hospital- CLSC in territories, all could promote the organization of care with regards to humanized birth care.

CHAPTER VI: GENERAL CONCLUSION

The findings of this study have shown that a large proportion of women with both normal, and high-risk pregnancies, prefer to deliver in a highly specialized hospital due to their fear of risks related to their baby's health, as well as their own. The humanization of birth practices in highly specialized hospitals should meet all the physiological, as well as psychological aspects of birth care. This includes respect for the fears, beliefs, values, and needs of women and their families. While at the same time competent professionals, provide the women with a personalized and family-centered care. The argument of medical intervention and technology at birth being an opposing factor to the humanization of birth was not seen to be an issue in the studied highly specialized university affiliated hospital. There were higher rates of administration of epidural analgesia in this hospital; however, the women participants stated that they made the decision to undergo such procedure because they wanted to have greater control over their delivery.

Any change in policy proposed by health care decision makers in this setting, should be brought about with sensitivity to women's view. Even if their pregnancy is normal, women should not be made to feel that they do not have the option of delivering in a highly specialized hospital. Women should feel empowered throughout their pregnancy, and childbirth should be a way for them to feel that they are in control of their bodies, and their labour when labour begins, no matter where they have chosen to give birth. The humanization of childbirth is seen as being practically impossible if the necessary information about the different forms of care is not provided to women, since this leads them to not having the real possibility of a choice.

The birthing environment of studied highly specialized hospital contained its own culture and structure, as well as its own language and technology which mostly focused on the risk and its management. Risk was in fact the dominant concern in the administrators group, as well as the health obstetric professionals, and women participants of the institution. In order to explore the facilitating factors and barriers present toward the humanization of birth care, one must redefine the terms of risk,

risk reduction, and risk management within such a setting. One must still consider the processes of risk management as an important part of the birth practices of a highly specialized hospital, but the humanization of childbirth should still be perceived as a main goal of the managers and health care professionals in such an environment.

The technocratic approach to birth will lead to a safer birth with the use of interventions and technology. Whilst worthy in terms of increasing the safety of women and their babies, and increasing positive clinical outcomes, at the same time, the alternative modes of birthing cannot in its methods exclude the psychosocial and humanized elements of birth care. The findings of the present study have shown that safety and humanization at birth are not contradictory at all; and that they are in fact, perceived as being the same thing. This is particularly important when we are thinking of the humanization of birth in a highly specialized hospital, as in this setting there is a higher tendency to impose the medicalized and technocratic model of birth. In such a context, some of the medicalized approaches to childbirth are appreciated by the women, and are even seen as being effective in enhancing their feelings of security and assurance. The establishment and practice of the humanized birth care model in a highly specialized hospitals thus a much greater goal than a simplistic opposition to medicalized birth care, and technological supremacy.

The implementation of the humanized birth care approach in a highly specialized university affiliated hospital has been found to demand policies in the healthcare system, which will guarantee availability of a place for birth for women from the moment they begin their pregnancy. The stress and anxiety resulting from the uncertainty of not having a place of birth, and the possibility of not having the choice of a care provider, as well as the probability of experiencing long waiting hours for appointments, leads to the dehumanization of birth. The women conceive that having a secured place in a birth center will help overlook the level of specialization of the chosen hospital, and that having a birth attendant of their own choice should not be a matter of *'luck',* but rather a routine service. Only this way, we can evolve the appropriate approach towards the humanization of birth.

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APPENDICE

ANNEX I: INTERVIEW GUIDE WITH PROFESSIONALS AND ADMINISTRATORS

(English and French version)

Semi-Structured Interview Guide for Administrators and Professional Participants

Participant's number …..
Date and hour…..

Humanized birth care

- Could you please tell me what is your definition of humanized care?
- Do you have any specific philosophy in this hospital regarding to humanized childbirth and care?
- What do you think about humanized care in high-risk pregnancy as well as low risk pregnancy in this hospital? What do you consider as a barrier to humanized care in high and low risk pregnancy? What do you consider as a facilitator to humanized care in high and low risk pregnancy?

History of institution

- Are you aware about the history of this hospital concerning its style of care and its potential humanized birth care practices?

- Are there any *event, strategy, founders' vision and leaders' view* in the history of this hospital which can be considered as facilitators or barriers towards humanized birth care practise in this institute?

Contingence

- Do you have any idea about the functioning of the hospital (e.g. technology, economy, rules) regarding its style of care and its potential humanized birth practices? What do you consider as a barrier to humanized care? What do you consider as a facilitator to humanized care?

Society

- Could you please describe the different type of clients that you meet in this hospital and their expectations from the hospital? What do you consider as eventual barriers that prevent the hospital from meeting these expectations of

humanized care? What do you consider as eventual facilitators that allow the hospital to offer such humanized care?

Structure

- Are you aware about the mission and the vision of the hospital regarding its physical environment, its organisation and its structure related to the prenatal care?
- What do you consider as a barrier to humanized care? What do you consider as a facilitator to humanized care?

Culture

- Are you aware about the values and culture of the hospital and its potential humanized professionnal practices and health care services?
- What do you consider as a barrier to humanized care? What do you consider as a facilitator to humanized care?

Do you have specific values or preferences, regarding to childbirth practice in this hospital?

Is there anything that you would like to share with me regarding the issue?

Socio-Demographic data:

Age

Educational level:

Professional status:

Experience

Guide d'entrevue semi- structuré pour administrateurs et participants professionnels

Numéro de participant----------
Date et heur----------

L'humanisation des soins

- Pourriez-vous me dire quelle est votre définition de l'humanisation de soins?
- Est- ce que vous avez une philosophie spécifique dans cet hôpital concernant l'humanisation des soins de naissance?
- Que pensez-vous des soins humanisés aussi bien pour la grossesse à haut risque que pour la grossesse à faible risque dans cet hôpital ? À votre avis quels sont les facilitateurs et les barrières aux pratiques des soins humanisés de naissance dans cet hôpital?

Histoire de l'institution

- Êtes- vous au courant de l'histoire de cet hôpital concernant son style de soins et ses pratiques de soins humanisé de naissance ?

- Il y a t-il d'événement, la stratégie ou la vision des fondateurs et dirigeant dans l'histoire de cet hôpital qui peut être considéré comme facilitateurs ou barrières pour les pratique des soins humanisés de naissance dans cet hôpital?

Contingence

- Avez vous une idée concernant le fonctionnement de l'hôpital (par exemple technologie, économique, règles, règlements,…) par rapport au style de soin et ses attitude de soins humanisé de naissance?

Société

- Pourriez-vous me décrire vos différents types de clients et leurs attentes de cet hôpital ?

Structure

- Êtes- vous au courant de la mission et de la vision de l'hôpital par rapport à son environnement physique, son organisation et ses pratiques potentielles de soins humanisé de naissance?

Culture

- Êtes- vous au courant des valeurs et de la culture de l'hôpital et ses pratiques potentielles de soins humanisé de naissance?

- Avez-vous des valeurs spécifiques ou des préférences des pratiques de naissance d'enfant dans cet hôpital?

Il y a t-il quelque chose que vous voudriez bien partager avec moi ?

Données Socio-démographiques :

Âge :

Niveau d'éducation :

Statut professionnel :

Expérience :

ANNEX II: INTERVIEW GUIDE WITH WOMEN

(English and French version)

Semi-Structured Interview Guide for Women Participants

Number of participant----------

Date & hour ----------

Humanized childbirth

- Could you please tell me about your experience during your pregnancy and delivery? *(How did you find the birth attendants? Did they encourage your full participation through childbirth, gave advice and encouragements? Were you free to communicate to your birth attendant?)*
- What do you know about humanized care and particularly about humanizing birth care? *(Do you think the care that you have received during your pregnancy and delivery was concordant with your definition of a humanized care?*

History of institution

- When you chose your hospital, were you aware about its health care or its medicine's reputation *(nature of care which it offers, status ...)?*

Contingency*

- Do you have any idea about the functioning and the characteristic of the hospital (*,such as the level of using technology, its economic, the rules, etc.)*

Society

- During your prenatal visits or staying in the hospital (before and after delivery) you have probably met other women and talked with them. Do you think that all the women who seek care at this hospital, have the same expectations that you have?

Structure

- What do you think about the physical environment, and the structure of this hospital related to the perinatal care?

CultureErreur ! Signet non défini.

- As a whole, are you aware about the values and culture of the hospital?
- Did you have any specific values, needs or reasons to choose this hospital?

Do you think that there is any issue that we did not address and that you would like to share with me?

Socio-Demographic data:

Age

Educational level

Employment

Ethnicity

Marital status

Guide d'entrevue semi-structurée avec les femmes

Numéro de la participante----------

Date et heure ----------

L'humanisation des soins périnatals

- Pourriez-vous me parler de votre expérience durant la grossesse et l'accouchement?
  (*Que pensez-vous de la personne qui vous a assistée durant votre accouchement? Est-ce qu'il ou elle vous a encouragée à vous impliquer activement dans votre accouchement? Est- ce qu'il ou elle vous a donné des conseils et des encouragements? Est-ce que vous étiez libre de communiquer avec la personne qui vous a assistée durant votre accouchement?)*

- Que savez-vous de l'humanisation des soins, et particulièrement de l'humanisation des soins à la naissance?
  (*Pensez-vous que les soins que vous avez reçus durant votre grossesse et votre accouchement* co*ncordent avec votre perception des soins humanisés?)*

Histoire de l'institution

- Est-ce que vous connaissiez bien l'hôpital Ste-Justine et sa réputation concernant les soins qu'il offre et la réputation de ses médecins (*Nature des soins offerts, statut…)?*

Contingence *

- Avez vous une idée sur le fonctionnement et les caractéristiques de Ste-Justine? (par exemple le niveau d'utilisation des technologies, ses règles, etc.)

Société

- Au cours de vos visites prénatales ou séjour(s) à Ste-Justine (avant et après votre accouchement) vous avez probablement rencontré et parlé à d'autres femmes. Pensez-vous que toutes les femmes qui cherchent les soins dans cet hôpital ont les mêmes attentes que vous?

---

* **Au besoin, ces concepts propres à l'étude seront clarifiés auprès de la femme interviewée.**

Structure *

- Que pensez-vous de l'environnement physique et de la structure de Ste-Justine en ce qui a trait aux soins périnatals ?

Culture *

- Globalement, êtes-vous informée des valeurs et de la culture de l'hôpital Ste-Justine?

- Est-ce que vous aviez des valeurs spécifiques, des besoins bien précis ou des raisons particulières qui vous ont incitée à choisir cet hôpital?

- Croyez-vous qu'il y a d'autres choses que nous n'avons pas abordées et que vous voudriez partager avec moi?

Données Socio- Démographiques:

Âge;
Niveau d'éducation ;
Emploi;
Appartenance ethnique;
Statut marital

ANNEX III: QUESTIONNAIRE

(English Version)

ANNEX IV: AUTHORIZATION LETTER FOR REVIEW OF MEDICAL RECORDS AND ARCHIVES

Sainte-Justine
1907-2007 100 ans
à faire grandir la vie.

Le 2 avril 2007

CHU Sainte-Justine
Le centre hospitalier universitaire mère-enfant

Pour l'amour des enfants

Université de Montréal

Madame Marie Hatem
Université de Montréal
C.P. 6128 Succ. Centre Ville
Montréal (Québec) H3C 3J7

Objet : Réponse à votre demande d'approbation de projet

Madame,

Il nous fait plaisir de vous donner l'autorisation de la Direction des services professionnels concernant votre demande de révision de dossiers médicaux dans le cadre de votre recherche intitulé : « Quelles sont les composantes d'humanisation de l'accouchement en milieu hospitalier hyperspécialisé: Une étude de cas organisationnelle ».

Nous transmettrons copie de votre demande au chef des archives médicales qui se fera un plaisir de vous aider dans votre démarche. Par ailleurs, si plusieurs dossiers sont archivés à l'extérieur, elle vous communiquera les frais encourus à votre demande.

Nous vous prions d'inclure cette lettre avec votre demande de projet de recherche au comité d'éthique à la recherche, s'il y a lieu.

Nous vous prions d'agréer, Madame, l'expression de nos sentiments les meilleurs.

Le Directeur des services professionnels intérimaire

Isabelle Amyot, m.d., f.r.c.p. (c)

/md

c.c. : Chef des archives
M. Therrien

RECH
BEHREC

3175, Côte-Sainte-Catherine
Montréal (Québec)
H3T 1C5
www.chu-sainte-justine.org

ANNEX V: OBSERVATION GRID OF DELIVERIES

Grid of Observation of Deliveries[2]

Delivery of ……

Observation Report Number….

Date and duration (start – end)……

Expectation for delivery/ Fears/context(childbirth)	Doctors Nurse(s) Accompany	**Information:** Who what when	**Decision:** Who what when	**Control:** Who What when	**Comment**

[2] Adapted from Vadeboncoeur (2004)

ANNEX VI: PAMPHLETS

(English and French Versions)

CHU Sainte-Justine

What are the components of Humanized Childbirth in a Highly Specialized Hospital? An Organizational Case Study

Université de Montréal

Introduction

The way women are cared and prepared for child birthing have an important influence not only on women's life but also on caring for the baby and bonding with it, continuity of good relationship with family and contribution to their social roles.

During the past decades, giving birth has developed into a highly routine and medicalized procedure. Humanizing birth is an alternative model for medical and technological childbirth. Humanized birth puts the woman in control of her own child birthing so that she contributes to making all the decisions about what will happen to her and her baby. The key principles in humanized birth are choice, continuity and control.

In a context of a high specialized 4th level hospital, most of the pregnancies are at high risk and have special needs that request special attention and care that surpass the needs of women with normal pregnancies and labour. Any attempt to provide standard humanized care in such a context, depend on the women's perception of humanized care, the organization of the institution providing care, and the severity of the obstetrical risk.

The present study aims:

The present survey aims to:

1) *define the humanized care in point of view of the women, the administrators, health professionals, physicians and nurses, in a highly specialized hospital such as the Saint-Justine hospital, and*
2) *to identify the facilitators' elements and the barriers to the offer of the humanized care in this type of hospital.*

Who can participate in the study?

This study addresses the women who:

- are 18 years or more;
- have either a normal or a high risk pregnancy;
- having given birth in the participating hospital (Hospital Sainte-Justine).
- being within 24 to 48 hours postpartum; and,
- are able to speak or read French or English;

What does it imply, for you, to participate in the study?

Before your involvement to the survey, you will be invited to sign a consent form. Your involvement to the survey implies that:

- You will be invited to participate in one of these two groups: the group «observation, interview, and questionnaire» or the group «Questionnaire».
  - The questionnaire will describe your experience of childbirth. It will be completed during your stay in the postpartum at the hospital.
  - Your authorization will allow an investigator, a doctoral student in public health of the university of Montreal, to be present during your labour and delivery to observe and write a few field notes.
  - This investigator will meet you through an interview for about 45 minutes after your childbirth to listen to your point of view concerning your experience of this event.
- During your stay at the hospital, certain information will be collected from your hospital charts regarding the health care and the services that you and your baby have received.

Risk and benefits of your participation to the study:

As no intervention will be applied in this study, there we will no risk for you to participate. Your participation to this study would help improve the knowledge around the concept of humanizing care in a highly specialized hospital and you would help the investigators to better understand the facilitators and barriers toward implementing humanized childbirth in the context of a high specialized hospital.

Confidentially and freedom to participate:

All information about you will be kept strictly confidential and a study number and data will be used on all forms and questionnaires instead of your specific names or any other identifying information. The signed consent forms and all other documents will be kept in separate cabinets, accessible only to the investigators. Data collected will be destroyed as soon as the articles presenting the results of the study are produced. You are completely free to participate or not in this study. Your withdrawal, at any time, will not have any consequence for you neither or any member of your family.

If you wish to have more information about the present study, please communicate with:

Main investigator:

Professor Marie Hatem
Telephone:

Coordinator(s):

Roxana Behruzi
Telephone:

CHU Sainte-Justine
Le centre hospitalier universitaire mère-enfant
Pour l'amour des enfants
Université de Montréal

Quelles Sont les Composantes D'humanisation de L'accouchement en Milieu Hospitalier Hyperspécialisé? Une Étude de Cas Organisationnelle

Université de Montréal

Introduction :

La manière de prendre en charge et de préparer les femmes à l'accouchement a une grande influence non seulement sur leur vie mais aussi sur leur façon de s'occuper de leur bébé, de s'attacher à lui, de développer de bon rapport avec la famille et de contribuer à leurs rôles sociaux.

Vers le milieu du siècle dernier, la grossesse et l'accouchement étaient conceptualisés comme des processus pathologiques qui requièrent souvent des interventions médicales. L'humanisation de la naissance est un modèle alternatif au modèle médical et technologique de la naissance. Dans le cadre de ce modèle, la femme serait en contrôle de la naissance de son enfant: elle participe à la prise de décision relative aux soins requis lors de son travail et de son accouchement, elle a plus confiance en elle, l'attachement s'établit naturellement avec son enfant et elle se sent plus compétente dans son rôle de parent. Les clés principales des soins périnatals humanisés seraient le choix, la continuité et l'auto-contrôle.

Dans un contexte de l'hôpital hyperspécialisé, la plupart des grossesses sont à haut risque obstétrical nécessitant une attention particulière. Toute tentative de fournir des soins humanisés dans un tel contexte, dépendrait à la fois de l'organisation de l'institution pourvoyeuse des soins, de la gravité du risque, et de la perception qu'a la femme des soins humanisés.

La présente étude vise à:

La présente étude vise à :

1) définir ce que sont des soins humanisés dans un centre hospitalier hyperspécialisé comme l'hôpital Sainte-Justine du point de vue des femmes, des administrateurs et des professionnels de la santé, médecins et infirmières, et

2) à identifier les éléments facilitateurs et les barrières à la dispensation de soins humanisés dans ce type de milieu.

Qui peut participer à l'étude?

Cette étude s'adresse aux femmes qui:

› ont 18 ans ou plus;
› ont eu une grossesse normale ou à haut risque;
› ont donné naissance à l'Hôpital Sainte-Justine;
› sont présents depuis environ 24 à 48 heures dans le postpartum et ;
› sont capables de parler ou lire le français ou l'anglais;

Que représente pour vous la participation à l'étude?

Avant votre participation à l'étude, vous serez invitée à signer un formulaire de consentement. Votre participation à l'étude implique le suivre:

› Vous serez invitée à participer à l'un ou l'autre des groupes : «Observation, entrevue et questionnaire» ou «Questionnaire».

› Le questionnaire décrira votre expérience d'accouchement. Il sera complété pendant votre séjour du post-partum à l'hôpital.

› L'observation sera réalisée par une étudiante au doctorat en santé publique de l'université de Montréal que vous autoriserez, si vous le souhaitez, à être présente pendant votre accouchement. Elle observera votre accouchement et prendra quelques notes sur son déroulement.

› Cette investigatrice vous rencontrera à travers une entrevue pour environ 45 minutes après votre accouchement pour écouter votre point de vue concernant votre expérience de cet événement.

› Pendant votre séjour à l'hôpital, certaines informations seront rassemblées à partir de votre dossier d'hôpital concernant les soins médicaux et les services que vous et votre bébé avez reçus.

Risque et avantages de votre participation à l'étude :

Comme aucune intervention ne sera appliquée dans cette étude, il n'y a aucun risque pour vous pour participer. Votre participation à cette étude aidera à améliorer la connaissance autour du concept d'humaniser le soin dans un hôpital très spécialisé et vous aiderez les investigateurs à mieux comprendre les facilitateurs et barrières pour que l'accouchement soit toujours humanisé dans le contexte d'un hôpital hyperspécialisé.

Confidentialité et liberté de participation

Toute l'information à votre sujet sera gardée strictement confidentielle. Tous les questionnaires et les entrevues se verront octroyer un numéro d'identification pour remplacer les noms ou tout autre identifiant. Les formulaires de consentement signés et tous les autres documents d'identification seront gardés dans des classeurs conservés sous clé, accessibles uniquement à la coordonnatrice du projet. Les données vous concernant seront détruites dès que les publications correspondant aux objectifs énoncés seront produites. Votre participation à cette étude est tout à fait volontaire. Vous êtes donc libre d'accepter ou de refuser d'y participer et vous pouvez vous retirer de l'étude en tout temps, sans que cela n'affecte les traitements auxquels vous avez droit, ni que cela ne nuise à vos relations avec votre médecin ou avec les membres de l'équipe soignante de l'établissement que vous côtoyez.

Si vous souhaitez avoir plus d'information au sujet de la présente étude, s'il vous plaît communiquez avec:

Investigatrice principale:
Professor Marie Hatem
Téléphone:
Coordonnatrice(s):
Roxana Behruzi
Téléphone:

ANNEX VII: CONSENT FORM FOR WOMEN

(English and French)

INFORMATION AND CONSENT FORM INTENDED FOR WOMEN

(Questionnaire, interview, observation group)

Title of project: ***What are the components of humanized childbirth in a highly specialized hospital? An organizational case study***

Name of the researcher(s):
Responsible researcher of the project:
Hatem Marie, Ph.D., Faculty of Medicine, Social and Preventive Medicine

Internal and external collaborators:
Francoeur Diane, MD, OB&GYN, Chief of the Department of Obstetrics and Gynecology, CHU Ste-Justine
Leroux Nathalie, MD, OB&GYN, Chief of the service of Gynecology, CHU Ste-Justine
Lise Goulet, MD, Ph.D., Faculty of Medicine, Social and Preventive Medicine
Leduc Nicole, Ph.D., Faculty of Medicine, Administration of Health
Blais Régis, Ph.D., Faculty of Medicine, Administration of Health
Lamothe Lise, Ph.D., Faculty of Medicine, Administration of Health

Source of financement: A demand for grant has been submitted to the Canadian Institute of health Research.

Invitation to participate in the research:
We solicit your participation to this survey. Your point of view with regard to the services that will be offered you during your stay in the hospital is very important. It allows us to collect specific information about your experience and to get your appreciation of the set of services offered in a highly specialized hospital. Besides, the survey aims to determine the barriers and the facilitators to the offer of a humanized care adapted to the potential level of risk that the woman or the child can present before, during or early after childbirth. It is important to really understand this form. Don't hesitate to ask your questions. You can take your time to make your decision

Description of the project:
The way women are cared for and prepared for child birthing have an important influence not only on their own life but also on caring for the baby and bonding with it, continuity of good relationship with family and contribution to their social roles. In Quebec, nearly 3 decades after the first critics by women's groups aiming at changing childbirth practices towards its humanization, the concept of humanized birth is still under debate. Although there have been some positive changes in order to humanize child birthing, compared to the care that were offered before this movement, it seems that childbirth has not really been de-medicalized in our hospitals.

The humanized birth care means to more active involvement in the decisions that are taken about mother case, the continuity of care that she receives, to let mother having more control on her own body and to appropriate use of obstetrical technology. In a high specialized hospital where most pregnancies are in high-risk, does the humanized care is the priority or the security of the mother and the child to be born? What about the low risk pregnancies? Are they treated similarly? What would be the best model of care offered to these types of clients?

The present survey aims to define the humanized care in point of view of the women, the administrators, health professionals, physicians and nurses, in a highly specialized hospital, such as the Saint-Justine hospital and to identify the facilitators' elements and the barriers to the offer of the humanized care in this type of hospital. Multiple sources of data will be used (eg. *interviews, observations, questionnaire and documentation).*

Procedure:
If you accept to participate in this study, you will be invited to participate to the group "observation, interview, questionnaire": if you accept to participate in this group, you will allow our research assistant, a health professional, to observe the progress of your childbirth and to take some notes. Within 24 to 48 hours postpartum period, you will be invited to complete a questionnaire and have an interview. The time requested to fill the questionnaire is about 30 minutes and the interview takes no more than 45 minutes. Data will be retrieved from your medical chart by the investigator. Maximum 10 women will take part to this intervention group.

Advantages and profits:
The findings of the survey will help to develop a model of cares that is being adapted to the level of obstetrical risk (high-risk or low risk pregnancy), fundamentally aims to promote, to protect and to support the humanized childbirth in the highly specialized hospitals, such as CHU Ste-Justine.

The health professionals, members of the multidisciplinary team, would get a global view of the context of care and services offered and would be able to make the decisions that would allow them to reach their objectives and adjust their practice accordingly, if necessary.

The administrators could adjust adequately the distribution of their resources according to the expectations of the population and the potential of the organization: levels of care or levels of obstetrical risk; place for the midwife according to the definition of the humanization in such a setting and among women not presenting an obstetrical risk but requiring the health services in overprotected hospital, etc. Such a study would enlighten the decision making on very applicable files that would be about socio-cultural, professional, political and economic issues. Indeed, humanized care are recognized to be more secure for women and less expensive for the health system.

Risks and inconveniences:
The survey doesn't present any risk or direct inconvenience for you. The moment of the interview will be chosen so that your comfort will be respected.

Possibility of suspension of the survey:
Your involvement to this survey can be interrupted if researcher(s) consider it for the benefit of participants, reasons of security or respect the human right.

Confidentiality:
All information about you will be kept strictly confidential (excluding exception of law) and a study number will be used on all forms and questionnaire instead of your specific name or any other identifying information. The signed consent form and all other documents will be kept in separate cabinets, accessible only to the investigators. The Ethic committee of research could have access to the data to make sure of the good progress of research.

In order to protect your confidentiality, your name and forename as well as those of your child, your coordinates, the date of the beginning and of the end of your participation to the study will be kept, by the principal investigator, during one year after the end of the study; this information will be approachable to the Ministry of Health and social services. Data concerning your participation will be destroyed as soon as the findings of study will have been published.

Liberty of participation
Your involvement to this survey is completely voluntary. You are therefore free to accept or to refuse to participate in this study and you can withdraw from the survey in all time without it affect the treatments to which you have right, nor that it harms to the relations with your physician. « By signing this consent form, you abandon none of your rights envisaged by law. Besides, you do not liberate the investigators neither from their legal nor from their professional responsibilities. »

Communication:
If you have a question or a doubt about the procedure of this survey, don't hesitate to contact the person responsible of the survey,

Professor Marie Hatem at .....or at the following address:
Marie Hatem, Ph.D.
Assistant Professor
University of Montreal
Faculty of Medicine,
Department of Social and Preventive Medicine,
Telephone:

Adherence to the project and signatures:

I read and understood the content of the present form. I certify that it was explained to me verbally. I had the opportunity to ask all questions concerning this research and the answers made me satisfied. I certify that I have had enough time to think and to make my decision. I know that I will be able to retire at any time. I agree to participate and I allow the assistant of research to consult my medical file to get the applicable information to this project.

I undersigned accept to participate in this survey.

_____	_____	_____
Name of the participant	Signature of the participant	Date

I certify having explained to the signatory:

a) the terms of the present consent form; b) that she remains free at anytime to put a term to her involvement in the present project; and, that I will hand her a copy of the signed form.

_____	_____	_____
Name of the researcher	Signature of the researcher	Date

Formulaire d'information et de consentement
DESTINÉ AUX FEMMES

(Groupe questionnaire, entrevue, observation)

Titre de l'étude : ***Quelles sont les composantes d'humanisation de l'accouchement en milieu hospitalier hyperspécialisé: Une étude de cas organisationnelle***

Nom des chercheur(s) :
Chercheur responsable du projet au CHU Sainte Justine :
Hatem Marie, Ph.D., Faculté de médecine - Médecine sociale et préventive
Collaborateurs internes et externes :
Francoeur Diane, MD, OB&GYN, chef de service du Département d'obstétrique et de gynécologie, CHU Ste-Justine
Leroux Nathalie, MD, OB&GYN, Chef de service de gynécologie, dépt

d'obstétrique- gynécologie, CHU Ste-Justine
Goulet Lise, MD, Ph.D., Faculté de médecine, Médecine sociale et préventive Leduc Nicole, Ph.D., Faculté de médecine, Administration de la santé
Blais Régis, Ph.D., Faculté de médecine - Administration de la santé
Lamothe Lise, Ph.D., Faculté de médecine - Administration de la santé

Source de financement : Une demande de subvention a été soumise aux Instituts de recherche en santé du Canada.

Invitation à participer à un projet de recherche :

Nous sollicitons votre participation à cette étude. Votre point de vue à l'égard des services qui vous seront offerts pendant votre séjour à l'hôpital est très important. Nous pourrons ainsi recueillir des informations spécifiques sur votre expérience et obtenir votre appréciation de l'ensemble des services offerts dans un hôpital hyperspécialisé. De plus, l'étude vise à déterminer les barrières et les facilitateurs à l'offre de services et de soins humanisés adaptés au niveau de risque que peut présenter la femme ou l'enfant à un moment donné de la période entourant la naissance. Il est important de bien comprendre ce formulaire. N'hésitez pas à poser des questions. Prenez le temps nécessaire pour prendre votre décision.

Description du projet :

La préparation des femmes à l'accouchement a une grande influence sur leur vie et sur leur façon de s'occuper et de s'attacher à leur bébé, de développer un bon rapport avec la famille et de jouer leurs rôles sociaux. Au Québec, environ trois décennies après le mouvement d'humanisation des soins entourant la maternité, le concept de naissance humanisée est toujours au cœur des débats. Même si certains changements ont été réalisés en vue de l'humanisation des soins en périnatalité, certains écrits

mentionnent que la naissance n'a pas été réellement démédicalisée dans les hôpitaux du Québec.

L'humanisation des soins entourant la maternité se traduit par un plus grand contrôle de la femme sur son propre corps, par sa participation active aux décisions qui sont prises à son sujet, par la continuité des soins qu'elle reçoit et par un recours adéquat à l'utilisation de la technologie obstétricale. Dans un hôpital hyperspécialisé où la plupart des grossesses sont à haut risque, l'humanisation des soins est-elle reléguée au second plan au détriment d'interventions visant à assurer la sécurité de la mère et de l'enfant à naître? Qu'en est-il des grossesses normales ou à faible risque? Sont-elles traitées de la même façon? Quel serait le modèle de soins offerts à ce type de clientèle?

La présente étude vise à définir ce que sont des soins humanisés dans un centre hospitalier hyperspécialisé comme l'hôpital Sainte-Justine du point de vue des femmes, des administrateurs et des professionnels de la santé, médecins et infirmières, et à identifier les éléments facilitateurs et les barrières à la dispensation de soins humanisés dans ce type de milieu. Des sources multiples de données seront utilisées (ex. entrevues, observations, questionnaires, documents).

Procédures:
Si vous acceptez de participer à ce groupe *« observation, entrevue, questionnaire »* vous autoriserez notre assistante de recherche, une professionnelle de la santé, à observer le déroulement de votre accouchement et à prendre des notes. Au cours des 24 à 48 heures qui suivent votre accouchement ou avant que vous obteniez votre congé de l'hôpital, vous serez invitée à remplir un questionnaire et à participer à une entrevue Le temps requis pour remplir le questionnaire est d'environ 30 minutes et l'entrevue, elle, est d'une durée d'environ 45 minutes. Votre dossier médical sera consulté pour obtenir quelques informations sur le déroulement de votre grossesse et accouchement. Au maximum, 10 femmes participeront à ce groupe d'intervention.

Avantages et bénéfices:
Les résultats de l'étude aideront à développer un modèle de soins qui tout en étant adapté au niveau de risque obstétrical (grossesse à risque élevé ou à faible risque) vise fondamentalement à promouvoir, protéger et supporter l'accouchement humanisé dans les hôpitaux hyperspécialisés comme le CHU Ste-Justine.

Les professionnels de la santé, membres de l'équipe multidisciplinaire, auraient également une vision globale du contexte des soins et des services offerts et pourraient prendre les décisions qui leur permettraient d'atteindre leurs objectifs à ce niveau et ajuster leur pratique, le cas échéant.

Les administrateurs pourraient voir à une répartition plus adéquate des ressources en fonction des attentes de la population et du potentiel de l'organisation : niveaux de soins ou niveaux de risques obstétricaux; place pour la sage-femme selon la définition de l'humanisation dans un tel milieu et auprès de femmes ne présentant pas de risque

obstétrical mais ayant recours à des services en milieu hospitalier surprotégé, etc. Une telle étude apporterait un éclairage pour la prise de décision sur des dossiers très pertinents qui porteraient sur des enjeux socioculturels, professionnels, politiques et économiques. En effet, les soins humanisés sont reconnus pour être plus sécuritaires pour les femmes et moins coûteux pour le système.

Risques et inconvénients:
L'étude ne présente aucun risque ni inconvénient directs connus pour vous. Le moment de l'entrevue sera choisi de telle sorte que votre confort sera respecté.

Éventualité d'une suspension de l'étude:
Votre participation à cette étude peut être interrompue si la/les chercheure/s considère/nt que c'est dans l'intérêt des participants ou pour des raisons de sécurité ou de respect des chartes de droit de la personne.

Confidentialité:
Toute l'information au sujet de votre participation sera gardée strictement confidentielle sauf exception de la loi. Le questionnaire et les données de l'entrevue se verront assigner un numéro d'identification pour remplacer votre nom ou tout autre identifiant. Le formulaire de consentement signé et tous les autres documents d'identification seront gardés sous clé dans des classeurs accessibles uniquement à la coordonnatrice du projet. À des fins de protection de votre vie privée, vos nom et prénom, vos coordonnées, la date du début et de la fin de votre participation au projet seront conservés, par le chercheur responsable, pendant un an après la fin du projet; ces informations seront accessibles au Ministère de la santé et des services sociaux. Les données concernant votre participation seront détruites dès que les résultats de l'étude auront été publiés. Le comité d'éthique de la recherche aura accès aux données pour s'assurer du bon déroulement de la recherche.

Liberté de participation
Votre participation à cette étude est tout à fait volontaire. Vous êtes donc libre d'accepter ou de refuser d'y participer et vous pouvez vous retirer de l'étude en tout temps sans que cela n'affecte les traitements auxquels vous avez droit, ni que cela ne nuise aux relations avec votre médecin ou avec les membres de l'équipe soignante de l'établissement. « En signant ce formulaire de consentement, vous ne renoncez à aucun de vos droits prévus par la loi. De plus, vous ne libérez les investigateurs et le promoteur du projet ni de leur responsabilité ni légale, ni de celle professionnelle. »

Communication :
Si vous avez une question ou un doute quant à la procédure de cette étude, n'hésitez pas à contacter la responsable de l'étude, professeur Marie Hatem au …..ou à l'adresse suivante:
Marie Hatem, Ph.D.
Professeur adjointe
Université de Montréal
Faculté de médecine,

Département de Médecine sociale et préventive,
Téléphone:
Vous pouvez communiquer avec le Commissaire local aux plaintes et à la qualité des services du CHU Sainte- Justine, pour obtenir des renseignements éthiques ou faire part d'un incident ou formuler des plaintes ou des commentaires au….

Consentement et assentiment :

J'ai lu et compris le contenu du présent formulaire. Je certifie qu'on me l'a expliqué verbalement. J'ai eu l'occasion de poser toutes les questions concernant ce projet de recherche et on y a répondu à ma satisfaction. Je certifie qu'on m'a laissé le temps voulu pour réfléchir et prendre ma décision. Je sais que je pourrai me retirer en tout temps. **J'autorise l'assistante de la recherche à consulter mon dossier médical pour obtenir les informations pertinentes à ce projet.**

Je soussigné(e) accepte de participer à cette étude.

_____	_____	_____
Nom de la participante	Signature de la participante	Date

Je certifie a) avoir expliqué au signataire les termes du présent formulaire de consentement; b) lui avoir clairement indiqué qu'il reste à tout moment libre de mettre un terme à sa participation au présent projet et que je lui remettrai une copie signée du présent formulaire.

_____	_____	_____
Nom du Chercheur	Signature du chercheur	Date

ANNEX VIII: CONSENT FORM FOR PROFESSIONAL AND ADMINISTRATORS

(French version)

FORMULAIRE D'INFORMATION ET DE CONSENTEMENT DESTINÉ AUX ADMINISTRATEURS ET AUX PROFESSIONNELS

Titre de l'étude : Quelles sont les composantes d'humanisation de l'accouchement en milieu hospitalier hyperspécialisé: Une étude de cas organisationnelle

Nom des chercheur(s) :
Chercheur responsable du projet au CHU Sainte Justine :
Hatem Marie, Ph.D., Faculté de médecine –Médecine sociale et préventive
Collaborateurs internes et externes :
Francoeur Diane, MD, OB&GYN, chef de service du Département d'obstétrique et de gynécologie, CHU Ste-Justine
Leroux Nathalie, MD, OB&GYN, CHU Ste-Justine
Goulet Lise, MD, Ph.D., Faculté de médecine, Médecine sociale et préventive
Leduc Nicole, Ph.D., Faculté de médecine, Médecine sociale et préventive
Blais Régis, Ph.D., Faculté de médecine - Administration de la santé
Lamothe Lise, Ph.D., Faculté de médecine - Administration de la santé

Source de financement : Une demande de subvention a été soumise aux Instituts de recherche en santé du Canada.

Invitation à participer à un projet de recherche :
Nous sollicitons votre participation à cette étude. Votre point de vue à l'égard des services qui sont offerts dans un hôpital très spécialisé est très important. Il nous permet de recueillir des informations spécifiques sur votre expérience et d'obtenir votre appréciation de l'ensemble des services offerts dans une organisation hospitalière de niveau quatre. De plus, l'étude vise à déterminer les barrières et les facilitateurs à l'offre de services et de soins humanisés et de qualité mais adaptés au contexte c'est-à-dire prenant en considération le niveau de risque que peut présenter la femme ou l'enfant à un moment donné de la période entourant la naissance. N'hésitez pas à poser des questions. Prenez votre temps pour prendre votre décision.

Description du projet :
L'humanisation de la naissance est un modèle alternatif au modèle médical et technologique de la naissance. Dans le cadre de ce modèle, la femme serait en contrôle de la naissance de son enfant: elle participe à la prise de décision relative aux soins requis lors de son travail et de son accouchement, elle a plus confiance en elle, l'attachement s'établit naturellement avec son enfant et elle se sent plus compétente dans son rôle de parent. Il est clair que cela est possible quand cet événement est à faible risque obstétrical. Cependant, si la littérature est abondante sur l'humanisation des naissances à faible risque obstétrical, celle-ci est quasi-muette quant au contexte de l'hôpital hyperspécialisé où la plupart des grossesses sont à haut risque.

Il serait pertinent de s'interroger sur l'applicabilité du modèle de soins humanisés lorsque les parturientes présentent une grossesse ou un accouchement à risque et où les urgences obstétricales requièrent une surveillance accrue. Cette question est légitime d'autant plus lorsque les parturientes sont suivies dans un hôpital de quatrième ligne en raison de la complexité de leur situation périnatale. Dans un tel contexte, faut-il prioriser les soins humanisés ou la sécurité de la femme et de l'enfant à naître? Peut-on envisager une adaptation des aspects de l'humanisation des soins aux caractéristiques des parturientes et aux soins requis par leur situation et par celle de leur(s) enfant(s)? Quel serait le modèle de soins offerts à ce type de clientèle? Toute tentative de fournir des soins humanisés dans un tel contexte dépendrait de la gravité du risque, de la perception qu'a la femme des soins humanisés et de l'organisation de l'institution pourvoyeuse des soins.

La présente étude vise : 1) à définir les soins humanisés qui apportent la satisfaction aux femmes qui requièrent/ont recours aux soins en milieu hyperspécialisé et 2) à explorer les dimensions organisationnelles et culturelles qui agiraient comme barrières ou facilitatrices pour des pratiques de soins garantes de tels soins humanisés et ce, dans un hôpital hyperspécialisé et affilié à une université au Québec.

Méthode : Comme stratégie de recherche, une « étude de cas » est considérée la plus appropriée à appliquer à l'institution retenue : Centre hospitalier universitaire Mère-Enfant de l'Hôpital Sainte Justine. La population visée comprend des administrateurs, des professionnels de l'équipe multidisciplinaire et des femmes (niveaux de risque obstétrical variés) admises pour accouchement dans cette institution. Des sources multiples de données seront utilisées.

Des entrevues semi structurées seront réalisées auprès des différents cadres administratifs et des chefs de service (direction hôpital, soins, médical, etc.), aux professionnels de la santé (MD, OB&GYN, anesthésiste, pédiatres, infirmières, etc.) ainsi qu'aux parturientes. Le questionnaire auquel répondront les personnes interviewées permettra de recueillir l'information relative aux perceptions du concept d'humanisation, et des caractéristiques de la société, de l'histoire de l'organisation, des contingences, de la structure, des individus et de la culture, qui peuvent représenter des facilitateurs ou des obstacles à l'offre de soins humanisés adaptés à un centre hospitalier de niveau 4.

Une enquête par questionnaire sera réalisée auprès de toutes les parturientes admises durant la période de collecte des données (3 mois). Elle explorera leurs attentes et leur satisfaction à l'égard des soins reçus au CHU Ste-Justine quant à leur qualité de soins humanisés.

Une observation de quelques suivis de travail et d'accouchement de parturientes.

Une analyse de documents ciblera ceux liés à l'histoire du CHU Ste-Justine, à sa structuration actuelle et future. L'analyse de tels documents permettra de corroborer, de trianguler les données et d'accroître les preuves des autres sources.

Procédures ou votre participation
L'entrevue avec vous sera réalisée à l'hôpital tel que décrit précédemment. La durée de l'entrevue sera d'environ 60 minutes.

Avantages et bénéfices: Les résultats de l'étude serviront pour développer un modèle conceptuel de soins en vue de promouvoir, protéger et supporter l'accouchement humanisé dans les hôpitaux hyperspécialisés.

Les professionnels de la santé, membres de l'équipe multidisciplinaire auraient également une vision globale du contexte des soins et des services rendus et pourraient prendre les décisions qui leur permettraient d'atteindre leurs objectifs à ce niveau et ajuster leur pratique, le cas échéant.

Les administrateurs pourraient voir à une répartition plus adéquates des ressources en fonction des attentes de la population et du potentiel de l'organisation : place aux soins de différents niveaux ou spécifiques aux grossesses à risque; place pour la sage-femme selon la définition de l'humanisation dans un tel milieu et auprès de femmes ne présentant pas de risque obstétrical mais ayant recours à des services en milieu hospitalier surprotégé, etc. Une telle étude apporterait un éclairage pour la prise de décision sur des dossiers très pertinents qui porterait sur des enjeux socioculturels, professionnels, politiques et économiques. En effet, les soins humanisés sont reconnus pour être plus sécuritaires pour les femmes et moins coûteux pour le système.

Risques et inconvénients:
L'étude ne présente aucun risque ni inconvénient directs connus pour vous. Le moment de l'entrevue sera choisi de telle sorte que votre confort sera respecté.

Éventualité d'une suspension de l'étude:
Votre participation à cette étude peut être interrompue si la/les chercheure/s considère/nt que c'est dans l'intérêt des participants ou pour des raisons de sécurité ou de respect des chartes de droit de la personne.

Confidentialité:
Toute l'information au sujet de votre participation sera gardée strictement confidentielle sauf exception de la loi. Toutes les données d'entrevue se verront octroyer un numéro d'identification pour remplacer le nom ou tout autre identifiant. Le formulaire de consentement signé et tous les autres documents d'identification seront gardés dans des classeurs conservés sous clé, accessibles uniquement à la

coordonnatrice du projet. Le comité d'éthique de la recherche aura accès aux données pour s'assurer du bon déroulement de la recherche.

À des fins de protection, votre nom et prénom, vos coordonnées, la date de début et de fin de votre participation au projet seront conservés pendant un an après la fin du projet par le chercheur responsable et seront accessibles au Ministère de la santé et des services sociaux. Les données concernant votre participation seront détruites dès que les publications correspondant aux objectifs énoncés seront produites.

Liberté de participation
Votre participation à cette étude est tout à fait volontaire. Vous êtes donc libre d'accepter ou de refuser d'y participer et vous pouvez vous retirer de l'étude en tout temps.
« En signant ce formulaire de consentement, vous ne renoncez à aucun de vos droits prévus par la loi. De plus, vous ne libérez pas les investigateurs et le promoteur de leur responsabilité légale et professionnelle. »

Communication :
Si vous avez une question ou un doute de la procédure de cette étude, n'hésitez pas à contacter la responsable de l'étude,–professeur Marie Hatem au … ou à l'adresse suivante:
Marie Hatem, Ph.D.
Professeur adjointe
Université de Montréal
Faculté de médecine,
Département de Médecine sociale et préventive,
Téléphone:
Vous pouvez communiquer avec le Commissaire local aux plaintes et à la qualité des services du CHU Sainte- Justine, pour obtenir des renseignements éthiques ou faire part d'un incident ou formuler des plaintes ou des commentaires au ….

Consentement et assentiment :

J'ai lu et compris le contenu du présent formulaire. Je certifie qu'on me l'a expliqué verbalement. J'ai eu l'occasion de poser toutes les questions concernant ce projet de recherche et on y a répondu à ma satisfaction. Je certifie qu'on m'a laissé le temps voulu pour réfléchir et prendre ma décision. Je sais que je pourrai me retirer en tout temps.

Je soussigné(e) accepte de participer à cette étude.

_____	_____	_____
Nom de la participante	Signature de la participante	Date

Je certifie a) avoir expliqué au signataire les termes du présent formulaire de consentement; b) lui avoir clairement indiqué qu'il reste à tout moment libre de mettre un terme à sa participation au présent projet et que je lui remettrai une copie signée du présent formulaire.

_____	_____	_____
Nom du Chercheur	Signature du chercheur	Date

ANNEX IV: RESEARCH ETHICS DOCUMENTATION

Sainte-Justine
1907-2007
à faire grandir la vie.

Le 08 août 2007

Mme Marie Hatem
Centre de recherche
Étage A Bloc 7

CHU Sainte-Justine
Le centre hospitalier universitaire mère-enfant

Pour l'amour des enfants

Université de Montréal

OBJET: Titre du projet: Quelles sont les composantes de l'humanisation de l'accouchement en milieu hospitalier hyperspécialisé: une étude de cas organisationnelle.

No. de protocole: 2549

Responsables du projet: Marie Hatem Ph. D., chercheure responsable au CHU Sainte-Justine et investigatrice principale. Collaborateurs: Nathalie Leroux MD, Lise Goulet MD, Nicole Leduc PhD, Régis Blais PhD, Lise Lamothe PhD

Madame,

Votre projet cité en rubrique a été approuvé par le Comité d'éthique de la recherche en date d'aujourd'hui. Vous trouverez ci-joint la lettre d'approbation du Comité, la liste des documents approuvés ainsi que vos formulaires estampillés dont nous vous prions de vous servir d'une copie pour distribution.

Tous les projets de recherche impliquant des sujets humains doivent être réexaminés annuellement et la durée de l'approbation de votre projet sera effective jusqu'au 19 juillet 2008 Notez qu'il est de votre responsabilité de soumettre une demande au Comité pour que votre projet soit renouvelé avant la date d'expiration mentionnée. Il est également de votre responsabilité d'aviser le Comité dans les plus brefs délais de toute modification au projet ainsi que de tout effet secondaire survenu dans le cadre de la présente étude.

Nous vous souhaitons bonne chance dans la réalisation de votre projet et vous prions de recevoir nos meilleures salutations.

Jean-Marie Therrien, Ph.D., éthicien
Président du Comité d'éthique de la recherche,

JMT/nd

3175, Côte-Sainte-Catherine
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Sainte-Justine
1907-2007 à faire grandir la vie.

LE COMITÉ D'ÉTHIQUE DE LA RECHERCHE

CHU Sainte-Justine
Le centre hospitalier universitaire mère-enfant

Pour l'amour des enfants

Université de Montréal

Un comité du CHU Sainte-Justine formé des membres suivants:

Jean-Marie Therrien, éthicien et président
Geneviève Cardinal, juriste
Françoise Grambin, représentante du public
Andréa Maria Laizner, scientifique
Caroline Laverdière, hémato-oncologue
Maii Thuy Luu, pédiatre
Lyne Pedneault, pharmacienne
Marie St-Jacques, infirmière de recherche
Chantal Van de Voorde, représentante du public
Observatrice: Catherine Hamelin

Maii Thuy Luu

Les membres du comité d'éthique de la recherche ont étudié le projet de recherche clinique intitulé:

- *Quelles sont les composantes de l'humanisation de l'accouchement en milieu hospitalier hyperspécialisé: une étude de cas organisationnelle.*

No. de protocole: 2549

soumis par: *Marie Hatem Ph. D., chercheure responsable au CHU Sainte-Justine et investigatrice principale. Collaborateurs: Nathalie Leroux MD, Lise Goulet MD, Nicole Leduc PhD, Régis Blais PhD, Lise Lamothe PhD*

et l'ont trouvé conforme aux normes établies par le comité d'éthique de la recherche du CHU Sainte-Justine. Le projet est donc accepté par le Comité.

Jean-Marie Therrien, Ph.D., éthicien
Président du Comité d'éthique de la recherche

Date d'approbation: 08 août 2007

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CHU Sainte-Justine
Le centre hospitalier universitaire mère-enfant

Pour l'amour des enfants

Université de Montréal

INVESTIGATRICE PRINCIPALE : Marie Hatem
PROJET INTITULÉ: Quelles sont les composantes de l'humanisation de l'accouchement en milieu hospitalier hyperspécialisé: une étude de cas organisationnelle/What are the components of humanized childbirth in a highly specialized hospital? An organizational case study
PROTOCOLE NO : **2549**

LISTE DES DOCUMENTS APPROUVÉS PAR LE CÉR
Estampillés en date du 8 août 2008

- Protocole de recherche (formulaire IRSC)
- Annexe I : Definition of the internal and external elements of organizationial culture model
- Annexe II : Conceptual Framework
- Annexe III : Guide d'entrevue semi-structuré pour administrateurs et participants professionnels
- Annexe IV : Semi-structured interview guide for administrators and professional participants
- Annexe V : Guide d'entrevue semi-structuré avec les femmes
- Annexe VI : Semi-structured interview guide for women participants
- Annexe VII (English Version) : Questionnaire intended for women
- Annexe VII (Version Française) : Questionnaire destiné aux femmes
- Annexe VIII : The operational definitions of the concepts
- Annexe IX : Grid of observation of deliveries
- Annexe IX : Grille d'observation de l'accouchement
- Annexe X : Plan of study
- Annexes XI & XII :
  - What are the components of humanized childbirth in a highly specialized hospital? An organizational case study
  - Quelles sont les composantes d'humanisation de l'accouchement en milieu hospitalier hyperspécialisé? Une étude de cas organisationnelle
- Annexe XIII : Formulaire d'information et de consentement destiné aux administrateurs et aux professionnels
- Annexe XIV : Formulaire d'information et de consentement destiné aux femmes (groupe questionnaire, entrevue, observation)
- Annexe XV : Formulaire d'information et de consentement destiné aux femmes (questionnaire auto-administré)
- Annexe XVI : Information and consent form intented for women (questionnaire group)
- Annexe XVII : Information and consent form intended for women (questionnaire, interview, observation group)

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Sainte-Justine 1907-2007 100 ans à faire grandir la vie.

Le 28 août 2009

Mme Marie Hatem
Médecine sociale et préventive
Université de Montréal
C.P. 6128, Succursale Centre-Ville

CHU Sainte-Justine
Le centre hospitalier universitaire mère-enfant

Pour l'amour des enfants

Université de Montréal

OBJET: Titre du projet: Quelles sont les composantes de l'humanisation de l'accouchement en milieu hospitalier hyperspécialisé: une étude de cas organisationnelle.

Recrutement terminé

No. de dossier: 2549

Responsables du projet: Marie Hatem Ph. D., chercheure responsable au CHU Sainte-Justine et investigatrice principale. Collaborateurs: Diane Francoeur, MD, Nathalie Leroux MD, Lise Goulet MD, Nicole Leduc PhD, Régis Blais PhD, Lise Lamothe PhD et Roxana Behruzi, assistante de recherche

Madame,

Votre projet cité en rubrique a été réapprouvé par le Comité d'éthique de la recherche en date du 21 août 2009. Vous trouverez ci-joint la lettre de réapprobation du Comité. Étant donné qu'il était indiqué dans votre rapport annuel que le recrutement des participants était terminé, les membres du Comité n'ont pas réexaminé votre formulaire d'information et de consentement.

Tous les projets de recherche impliquant des sujets humains doivent être réexaminés annuellement et la durée de l'approbation de votre projet sera effective jusqu'au **21 août 2010**. Notez qu'il est de votre responsabilité de soumettre une demande au Comité pour le renouvellement de votre projet avant la date d'expiration mentionnée. Il est également de votre responsabilité d'aviser le Comité de toute modification à votre projet ainsi que de tout effet secondaire survenu dans le cadre de la présente étude.

Nous vous souhaitons bonne chance dans la réalisation de votre projet et vous prions de recevoir nos meilleures salutations.

Geneviève Cardinal, juriste
Président du Comité restreint du CÉR

GC/nh

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Sainte-Justine
1907-2007
à faire grandir la vie.

LE COMITÉ RESTREINT DU CÉR

Un comité du CHU Sainte-Justine formé des membres suivants:

Geneviève Cardinal, juriste
Marie St-Jacques, infirmière de recherche
Valérie Tremblay, infirmière de recherche

CHU Sainte-Justine
Le centre hospitalier universitaire mère-enfant

Pour l'amour des enfants

Université de Montréal

Les membres du comité restreint du CÉR ont étudié le projet de recherche clinique intitulé:

Quelles sont les composantes de l'humanisation de l'accouchement en milieu hospitalier hyperspécialisé: une étude de cas organisationnelle.

Recrutement terminé

No. de dossier: 2549

soumis par: *Marie Hatem Ph. D., chercheure responsable au CHU Sainte-Justine et investigatrice principale. Collaborateurs: Diane Francoeur, MD, Nathalie Leroux MD, Lise Goulet MD, Nicole Leduc PhD, Régis Blais PhD, Lise Lamothe PhD et Roxana Behruzi, assistante de recherche*

et l'ont trouvé conforme aux normes établies par le comité restreint du CÉR du CHU Sainte-Justine. Le projet est donc accepté par le Comité.

Geneviève Cardinal, juriste
Président du Comité restreint du CÉR

Date d'approbation: 21 août 2009

Comité d'éthique de la recherche

Président :
Jean-Marie Therrien, Ph.D
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Vice-présidente :
Geneviève Cardinal, avocate
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Soutien administratif :

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AVIS DE RENOUVELLEMENT

Le 1 juin 2010

Madame Marie Hatem
Médecine sociale et préventive
Université de Montréal

OBJET: Renouvellement du projet de recherche intitulé :
Quelles sont les composantes de l'humanisation de l'accouchement en milieu hospitalier hyperspécialisé: une étude de cas organisationnelle.

Recrutement terminé
Notre référence: dossier # 2549
Dernière date d'approbation: 21 août 2009

Madame,

L'approbation du comité d'éthique de la recherche (CÉR) pour un projet de recherche est valable pour un an seulement. L'approbation de votre projet mentionné en rubrique expire le 21 août 2010.

Par conséquent, vous devez soumettre l'original et 3 copies, du formulaire de renouvellement ci-joint avant le 22 juin 2010 afin de respecter les délais prévus.

Si votre projet est terminé, vous devez quand même compléter le formulaire de renouvellement (1 seule copie) afin que le CÉR procède à la fermeture officielle du dossier.

Nous désirons porter à votre attention qu'en vertu de la *Politique d'examen continu des projets de recherches en cours*, les projets doivent donc être renouvelés sur une base annuelle.

Pour votre information, sachez que :

Continuer un projet de recherche après l'expiration de sa dernière date d'approbation constitue un manquement aux lois et autres normes applicables et compromet la couverture d'assurances des chercheurs en matière de responsabilité civile.

Le comité d'éthique de la recherche a le pouvoir de mettre fin à toute étude qui ne respecte pas la *Politique d'examen continu des projets de recherche en cours*.

Nous vous remercions de votre collaboration et nous vous prions de recevoir l'expression de nos sentiments les meilleurs.

Geneviève Cardinal, juriste
Président du comité restreint du CÉR

Pièce jointe: Formulaire de renouvellement

CHU Sainte-Justine
Le centre hospitalier universitaire mère-enfant

Pour l'amour des enfants

Université de Montréal

Comité d'éthique de la recherche

Président :
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Vice-présidente :
Geneviève Cardinal, avocate
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ANNEX X: MATRIX I

ANNEX XI: HUMANIZED BIRTH IN HIGH-RISK PREGNANCY: BARRIERS AND FACILITATING FACTORS

Behruzi, R., M. Hatem, et al. (2010). "Humanized birth in high-risk pregnancy: barriers and facilitating factors." Med Health Care Philos 13(1): 49-58.

ANNEX XII: DEFINITION OF MEGA CODES

Table 1: The description of mega codes of the present study

Mega Codes	Description
Humanization of child birth	It encompasses the perception, assumption, definition regarding to humanized birth care.
History	Any issue regarding to humanizing birth in the history of establishment of the institution, the aim of the institution and its development, the recent past and present leader's views and values about childbirth practice particularly humanizing one , the successes and failures of previous strategies in implanting humanizing birth practice in this hospital and the reasons for, and as a whole all the factors in the history of the hospital which have been had the facilitators or obstacles roles in implanting humanized birth practice.
Contingency	It is defined as events all over the place to which must fit the organization. In the present study, the concept of contingency encompass : the *technology, the economic, the rules and the regulations*, *the practice guidelines,* that are adapted by the institution and that can be considered as facilitators or barriers of humanized birth practice in the hospital.
Society	It indicates the cultural, political and juridical environments, including religious beliefs and the values of the ambient society which the organization must adjust. In the present study, the ambient society refers to the waiting of the society (related to the culture and to the value and beliefs of the population) of care provided in a highly specialized hospital.
Socio-structural	It encompass; the institution's strategies about humanized birth , the institution special goals, power structure, professional's environment (e.g. team work trust, sharing and transforming care, equips spirits), rewards, motivations and compensations which could act as facilitators or barriers towards humanizing birth practice.
Culture	It refers to every symbol, ideology and value flow through the institution and its individuals which might act as a facilitator or barrier towards humanizing birth in the hospital.

Individual	**It encompasses the administrators, professional, as well as the parturient women's ambient, needs, motives, cultural competences, and values.**

ANNEX XIII: MATRIX II

ANNEX XIV: FACILITATORS AND BARRIERS IN THE HUMANIZATION OF CHILDBIRTH PRACTICE IN JAPAN

Behruzi, R., M. Hatem, et al. (2010). "Facilitators and barriers in the humanization of childbirth practice in Japan." BMC Pregnancy Childbirth 10(1): 25.